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HOSPITAL COST CONTAINMENT AND END STAGE RENAL DISEASE PROGRAM

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

S. 1391

TO ESTABLISH A TRANSITIONAL SYSTEM OF HOSPITAL COST CONTAINMENT BY PROVIDING FOR INCENTIVES AND RESTRAINTS TO CONTAIN THE RATE OF INCREASE IN HOSPITAL REVENUES, TO ESTABLISH A SYSTEM OF CAPITAL ALLOCATION DESIGNED TO ENCOURAGE COMMUNITIES TO AVOID THE CREATION OF UNNEEDED AND DUPLICATIVE HOSPITAL FACILITIES AND SERVICES, TO PROVIDE FOR THE PUBLICATION AND DISCLOSURE OF INFORMATION USEFUL TO THE PUBLIC IN MAKING DECISIONS ABOUT HEALTH CARE, TO PROVIDE FOR THE DEVELOPMENT OF PERMANENT REFORMS IN HOSPITAL REIMBURSEMENT DESIGNED TO PROVIDE INCENTIVES FOR THE EFFICIENT AND EFFECTIVE USE OF HOSPITAL RESOURCES, AND FOR OTHER PURPOSES

S. 1470

TO PROVIDE FOR THE RETURN OF THE ADMINISTRATIVE AND REIMBURSEMENT PROCEDURES CURRENTLY EMPLOYED UNDER THE MEDICARE AND MEDICAID PROGRAMS, AND FOR OTHER PURPOSES

H.R. 8423

TO AMEND TITLES II AND XVIII OF THE SOCIAL SECURITY ACT TO MAKE IMPROVEMENTS IN THE END STAGE RENAL DISEASE PROGRAM PRESENTLY AUTHORIZED UNDER SECTION 226 OF THAT ACT, AND FOR OTHER PURPOSES

OCTOBER 12, 13, AND 21, 1977

Printed for the use of the Committee on Finance

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HOSPITAL COST CONTAINMENT AND END STAGE RENAL DISEASE PROGRAM

WEDNESDAY, OCTOBER 12, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 8 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge and Dole.

Senator TALMADGE. The hearing will be in order.

[The committee press release announcing these hearings and the text of the bills S. 1391, S. 1470, and H.R. 8423 follow:]

FINANCE COMMITTEE ANNOUNCES HEARINGS ON HOSPITAL COST CONTAINMENT PROPOSALS AND H.R. 8423, IMPROVEMENTS IN MEDICARE RENAL DISEASE PROGRAM

Senator Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Senate Finance Committee announced today that the Subcommittee will hold hearings on the various pending hospital cost containment proposals. The hearings will be held beginning at 8:00 a.m. each day beginning October 11 through October 14 in Room 2221, Dirksen Senate Office Building.

The pending proposals include S. 1391, as reported by the Senate Committee on Human Resources. Senator Talmadge noted that S. 1391, as introduced, is the proposal supported by the Administration. Senator Talmadge said that he also anticipates substantial testimony on his expanded version of the hospital cost provisions in S. 1470, the "Medicare and Medicaid Administrative and Reimbursement Reform Act." A detailed outline of the new approach is expected to be released in the next day or two, according to Senator Talmadge, so that witnesses will be able to comment.

Testimony will also be received on H.R. 8423, a House-passed bill designed to improve Medicare administration and operation of coverage for patients suffering from kidney failure.

Requests to Testify.—Senator Talmadge advised that witnesses desiring to testify during this hearing make their request to testify to Michael Stern, Staff Director, Committee on Finance, 2227 Dirksen Senate Office Building, Washington, D.C. 20510, not later than Thursday, October 6, 1977. Witnesses will be notified as soon as possible after this date as to when they are scheduled to appear. Once the witness has been advised of the date of his appearance, it will not be possible for this date to be changed. If for some reason the witness is unable to appear on the date scheduled, he may file a written statement for the record of the hearing in lieu of a personal appearance.

Consolidated Testimony.—Senator Talmadge also stated that the Subcommittee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Subcommittee. This procedure will enable the Subcommittee to receive a wider expression of views than it might otherwise obtain. Senator Talmadge urged very strongly that all witnesses exert a maximum effort to consolidate and coordinate their statements.

Legislative Reorganization Act.—In this respect he observed that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress "to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument."

Senator Talmadge stated that in light of this statute and in view of the large number of witnesses who have already formally requested an opportunity to appear before the Subcommittee in the limited time available for the hearings, all witnesses who are scheduled to testify must comply with the following rules:

(1) A copy of the statement must be filed by the close of business the day before the witness is scheduled to appear.

(2) All witnesses must include with their written statement a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 75 copies must be submitted before the beginning of the hearing.

(4) Witnesses are not to read their written statements to the Subcommittee, but are to confine their ten-minute oral presentations to a summary of the points included in the statement.

(5) Not more than ten minutes will be allowed for the oral summary. Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written Statements.—Witnesses who are not scheduled for oral presentation, and others who desire to present their views to the Subcommittee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearings. These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227, Dirksen Senate Office Building not later than October 20, 1977.

95TH CONGRESS
1ST SESSION

S. 1391

IN THE SENATE OF THE UNITED STATES

APRIL 26 (legislative day, FEBRUARY 21), 1977

Mr. KENNEDY (for himself, Mr. ANDERSON, and Mr. HATHAWAY) introduced the following bill; which was read twice and referred to the Committees on Finance and Human Resources jointly by unanimous consent

A BILL

To establish a transitional system of hospital cost containment by providing for incentives and restraints to contain the rate of increase in hospital revenues, to establish a system of capital allocation designed to encourage communities to avoid the creation of unneeded and duplicative hospital facilities and services, to provide for the publication and disclosure of information useful to the public in making decisions about health care, to provide for the development of permanent reforms in hospital reimbursement designed to provide incentives for the efficient and effective use of hospital resources, and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1

SHORT TITLE

2

SECTION 1. This Act may be cited as the "Hospital
3 Cost Containment Act of 1977".

4

REPORT ON PERMANENT REFORM IN THE DELIVERY AND

5

FINANCING OF HEALTH CARE

6

SEC. 2. The Secretary of Health, Education, and Wel-
7 fare (hereinafter in this Act referred to as the "Secretary")
8 shall submit to the Congress, no later than March 1, 1978,
9 a report setting forth his recommendations for permanent
10 reforms in the delivery and financing of health care which
11 will increase the efficiency, effectiveness, and quality of
12 health care in the United States and which will replace the
13 transitional provisions of title I of this Act.

14

TITLE I—TRANSITIONAL HOSPITAL COST

15

CONSTRAINT PROVISIONS

16

PART A—PURPOSE AND GENERAL DESCRIPTION OF

17

THE PROGRAM

18

PURPOSE

19

SEC. 101. It is the purpose of the transitional hospital
20 cost containment program established by this title to con-
21 strain the rate of increases in total acute care hospital in-
22 patient costs, beginning October 1, 1977, and continuing
23 until the adoption of the permanent reforms referred to in
24 section 2, by limiting the amount of revenue which may be
25 received, by the hospitals involved, from Government pro-

1 grams, private insurers, and individuals who pay directly
2 for such care.

3 GENERAL DESCRIPTION OF PROGRAM

4 SEC. 102. (a) In order to carry out the purpose of the
5 transitional program as set forth in section 101, the inpatient
6 revenues of short-term acute care and specialty hospitals
7 (excluding new hospitals and certain Health Maintenance
8 Organization related hospitals) are to be limited in the man-
9 ner outlined in the succeeding provisions of this section (and
10 more particularly described in parts B and C of this title).

11 (b) The increase in total revenue which a hospital (as
12 defined in section 121) may receive in any accounting year
13 in the form of—

14 (1) reimbursement paid under the medicare and
15 medicaid programs, and by cost payers, for inpatient
16 services, and

17 (2) charges imposed upon other persons for in-
18 patient services,

19 may not, on a per-admission basis, exceed the average in-
20 patient reimbursement due or inpatient charges imposed per
21 inpatient admission in the base period (in general, the hos-
22 pital's accounting year ending in 1976) by more than the
23 percentage which is applicable to the hospital for such ac-
24 counting year under section 111.

1 (c) Such percentage, in the case of any hospital for any
2 accounting year, is to be determined by—

3 (1) establishing for such year, under section 112

4 (b), an “inpatient hospital revenue increase limit” based
5 on increases in the gross national product deflator and in
6 total hospital expenditures nationwide,

7 (2) modifying the limit so established by the “ad-
8 mission load formula”, as promulgated under section
9 113, to take account of major changes in patient loads
10 experienced by that particular hospital, in order to
11 arrive at an “adjusted inpatient hospital revenue in-
12 crease limit” for that hospital in such year, and

13 (3) applying such adjusted limit for periods after
14 September 30, 1977, with recognition being given under
15 section 111 (a) (1) to cost increases prior to that date.

16 (d) An exception from the limits otherwise established
17 may be granted in accordance with section 115 (for a par-
18 ticular period) to any hospital which is experiencing sub-
19 stantially higher costs as a result of extraordinary changes
20 in patient loads or major changes in facilities and services,
21 to the extent required to assure that the necessary additional
22 revenue will be available where necessary to meet actual
23 community needs.

24 (e) Compliance with these limits is to be enforced, in
25 accordance with section 116, in various ways. Such compli-

1 ance is required under the medicare program by directly
 2 applying the limits for purposes of both interim and final
 3 reimbursement. Amounts paid to hospitals under the med-
 4 icaid program in excess of such limits will be disallowed
 5 as a basis for Federal matching payments. Hospitals and non-
 6 government cost payers exceeding the limits will be subject
 7 to a Federal excise tax in an amount equal to 150 per centum
 8 of the excess (except in the case of a hospital which is
 9 exempt as a result of corrective actions as prescribed under
 10 section 116 (d) (2)).

11 (f) The Secretary is authorized, under section 117, to
 12 waive the limits otherwise established for all hospitals located
 13 in any State which has had in effect for at least one year
 14 a hospital cost containment program which covers at least
 15 90 per centum of all acute care hospitals in the State, applies
 16 to all payers except the medicare program, limits inpatient
 17 hospital revenue increases to a rate no greater (in the aggre-
 18 gate) than the rate established for the period involved under
 19 section 112 (b) , and provides for return of excess hospital
 20 revenues.

21 PART B—ESTABLISHMENT OF HOSPITAL COST
 22 CONTAINMENT PROGRAM

23 IMPOSITION OF LIMIT ON HOSPITAL REVENUE INCREASES

24 SEC. 111. (a) The average reimbursement paid to a
 25 hospital for inpatient services under title XVIII of the

1 Social Security Act, under a State plan approved under title
2 V or title XIX of such Act, or by any cost payer, and the
3 average charges imposed by a hospital for inpatient services,
4 in any accounting year any part of which falls within a
5 period subject to this title, may not (except as provided in
6 subsection (b)) exceed the base inpatient hospital revenue
7 per inpatient admission (as established under section 114)
8 by a percentage greater than the sum of—

9 (1) the percentage by which the costs involved
10 would have increased in the period elapsing after the
11 close of the hospital's base accounting year and prior to
12 October 1, 1977, if such costs had increased (during that
13 period) at the average annual rate actually experienced
14 by the hospital during the two-year period ending
15 with the close of such base accounting year, except that
16 such percentage as applied for purposes of this section
17 shall not be more than 15 per centum nor less than 6
18 per centum,

19 (2) the percentage by which such costs would have
20 increased in the period elapsing after September 30,
21 1977, and prior to the first day of the accounting year
22 for which the limit is being imposed if such costs had in-
23 creased (during such period) at an annual rate consistent
24 with the inpatient hospital revenue increase limit deter-
25 mined and promulgated under section 112(b), and

1 (3) the percentage by which such costs would have
2 increased in the accounting year for which the limit is
3 being imposed if such costs had increased (during such
4 year) at an annual rate consistent with the adjusted in-
5 patient hospital revenue increase limit applicable to the
6 hospital under section 112 (a) .

7 (b) Where less than a full accounting year falls within
8 a twelve-month period subject to this title, the limit set forth
9 in subsection (a) of this section, and the limit established
10 under section 112 (a) , shall apply with respect to reimburse-
11 ment due or charges imposed for the part of such accounting
12 year which falls within such period in the same proportion
13 as the number of days in such accounting year that fall within
14 such period bears to the total number of days in such ac-
15 counting year.

16 DETERMINATION OF ADJUSTED INPATIENT HOSPITAL
17 REVENUE INCREASED LIMIT

18 SEC. 112. (a) The "adjusted inpatient hospital revenue
19 increase limit" which is applicable to any hospital for pur-
20 poses of section 111 (a) (3) with respect to any accounting
21 year shall (subject to section 111 (b) and section 124) be
22 equal to the inpatient hospital revenue increase limit deter-
23 mined and promulgated under subsection (b) of this section
24 for the twelve-month period in which such accounting year
25 or any part thereof falls, modified by the application of the

1 "admission load formula" which is promulgated under sec-
2 tion 113 and applied to that hospital.

3 (b) (1) Between July 1 and October 1 of each calendar
4 year beginning with 1977, the Secretary shall promulgate a
5 figure which (subject to paragraph (2)) shall be the "in-
6 patient hospital revenue increase limit" applicable to the
7 twelve-month period beginning October 1 in such year (with
8 each such twelve-month period being referred to in this title
9 as a "period" or a "period subject to this title"). Such
10 figure shall be the sum of—

11 (A) the implicit price deflator of the gross national
12 product as calculated by the Bureau of Economic Analy-
13 sis of the Department of Commerce and published in
14 the Survey of Current Business (hereinafter in this title
15 referred to as the "gross national product deflator") for
16 the twelve-month period ending June 30 of such year,
17 and

18 (B) one-third of the difference between—

19 (i) the average annual rate of increase in total
20 hospital expenditures which is found by the Secre-
21 tary to have occurred during the twenty-four-month
22 period ending on the day preceding January 1 of
23 such calendar year, and

24 (ii) the annual rate of increase in the gross
25 national product deflator for the twenty-four-month

1 period ending on the day preceding January 1 of
2 such calendar year.

3 (2) If the Secretary finds during any period subject
4 to this title that the gross national product deflator with
5 respect to such period is expected to exceed by more than
6 one percentage point the gross national product deflator
7 which was used in making the determination under para-
8 graph (1) (or in making a prior adjustment under this
9 paragraph), the Secretary shall increase (or further in-
10 crease) the gross national product deflator so used by the
11 amount of such excess; except that no adjustment made
12 under this paragraph shall be effective with respect to any
13 accounting year ending prior to the calendar quarter pre-
14 ceding the calendar quarter in which such adjustment is
15 made.

16 PROMULGATION OF ADMISSION LOAD FORMULA

17 SEC. 113. The "admission load formula" shall be pro-
18 mulgated by the Secretary by October 1, 1977, and shall be
19 such that—

20 (1) a hospital will be allowed an increase in total
21 revenue from inpatient services in any accounting year
22 to the extent (and only to the extent) consistent with
23 the inpatient hospital revenue increase limit promul-
24 gated under section 112(b), for the period in which
25 such accounting year or any part thereof falls if ad-

missions in such accounting year have increased by less than 2 per centum or declined by less than 6 per centum as compared to the base accounting year (2 per centum and 10 per centum, respectively, in the case of a hospital with no more than four thousand admissions in the base accounting year) ;

(2) in the case of a hospital whose admissions in any accounting year are beyond the applicable range set forth in paragraph (1), the amount of total revenue from inpatient services in such year which is otherwise allowed under paragraph (1) shall be further increased for each admission above such range by one-half of the average revenue per admission that would have been allowed under paragraph (1) if the actual percentage change in admissions (as compared to the base accounting year) had been zero, or shall be reduced for each admission below such range by one-half of the average revenue per admission that would have been so allowed, except as provided in paragraph (3) ; and

(3) in the case of a hospital which had more than four thousand admissions in the base accounting year, no additional revenue will be allowed for increased admissions (with respect to any accounting year) beyond 15 per centum above those in the base accounting year, but the revenue otherwise permitted such a hospital under

1 paragraphs (1) and (2) shall be reduced (dollar for
2 dollar) for decreased admissions (in that year) beyond
3 15 per centum below those in the base accounting year.

4 BASE INPATIENT HOSPITAL REVENUE

5 SEC. 114. (a) (1) The revenue base for application of
6 the adjusted inpatient hospital revenue increase limit with re-
7 spect to any hospital in any accounting year shall (subject to
8 subsection (b)) be the revenue from reimbursement due and
9 inpatient charges imposed for inpatient hospital services pro-
10 vided in the hospital's base accounting year (as defined in
11 paragraph (2)).

12 (2) For purposes of this title, a hospital's "base ac-
13 counting year" is its accounting year which ended in 1976,
14 or, in the case of a hospital which did not meet the definition
15 contained in section 121 for at least one full accounting year
16 prior to an accounting year ending in 1976 in which it met
17 such definition, the accounting period immediately prior to
18 the first accounting year in which it satisfied such definition.

19 (b) The base revenue established for any hospital by
20 subsection (a) shall (except as provided in subsection (c))
21 be reduced by an amount equal to any inpatient charges in
22 such base accounting year for elements of inpatient services
23 for which payment is not made to the hospital in an account-
24 ing year any part of which falls within a period subject to
25 this title.

(c) Subsection (b) shall not apply with respect to revenue for inpatient services which have been found inappropriate under section 1523 (a) (6) of the Public Health Service Act by the State health planning and development agency designated under section 1521 of such Act for the State in which the hospital involved is located.

ESTABLISHMENT OF EXCEPTIONS

SEC. 115. (a) The Secretary shall have authority to grant exceptions from the limits established under this title to individual hospitals for particular periods, but in any case only to the extent that the hospital requesting the exception provides evidence satisfactory to the Secretary—

(1) of the extent to which costs of providing inpatient hospital services in an accounting year any part of which falls within a period subject to this title exceed such costs in the base accounting year as the result of—

(A) changes in admissions beyond the range specified in section 113 (3), or

(B) changes in capacity or in the character of inpatient services available in the hospital or major renovation or replacement of physical plant, but only if such changes have increased inpatient costs per admission by more than one-third of the difference specified in section 112 (b) (1) (B) over inpatient care costs per admission in the previous accounting year;

1 (2) that the revenue otherwise allowable (taking
2 into account all other available resources) is insufficient
3 to assure the solvency of the hospital as indicated by
4 the existence of a current ratio of assets to liabilities
5 (determined in accordance with the last sentence of
6 this subsection) of less than the ratio which the Sec-
7 retary estimates is being experienced by 25 per centum
8 or less of the hospitals subject to this title; and

9 (3) that the changes in admissions, capacity, plant,
10 or services available generating the excess costs de-
11 scribed in paragraph (1) have been found to be needed
12 under section 1523 (a) (5) of the Public Health Service
13 Act or appropriate under section 1523 (a) (6) of the
14 Public Health Service Act by the State health planning
15 and development agency, designated under section 1521
16 of such Act for the State in which the hospital involved
17 is located.

18 For purposes of paragraph (2), the term "current ratio of
19 assets to liabilities", with respect to any hospital, means the
20 sum of the cash, notes and accounts receivable (less reserves
21 for bad debts), marketable securities, and inventories held
22 by such hospital divided by the sum of all liabilities of such
23 hospital falling due in an accounting year for which the ex-
24 ception is requested under this section.

25 (b) The Secretary shall either approve any request for

1 an exception made by a hospital under subsection (a), or
2 deny such request, within a period not to exceed ninety days
3 after the hospital has filed in a manner and form prescribed
4 by the Secretary the evidence required by such subsection.
5 Any such request not denied within such ninety-day period
6 shall be deemed approved.

7 (c) Any hospital granted an exception under this sec-
8 tion must make itself available for an operational review by
9 the Secretary. The findings from any such review shall be
10 made public, and continuance of the exception shall be con-
11 tingent on implementation of any recommendations which
12 may be made (as a result of such operational review) for
13 improvements to increase efficiency and economy.

14 (d) (1) If the Secretary grants an exception with re-
15 spect to any accounting year to a hospital which had four
16 thousand or more admissions in the base accounting
17 year on the grounds set forth in subsection (a) (1) (A),
18 such hospital shall be allowed increased revenue for purposes
19 of this title as though it were a hospital with fewer than
20 four thousand admissions in such base year under section 113.

21 (2) If the Secretary grants an exception with respect
22 to any accounting year to a hospital on the grounds set forth
23 in subsection (a) (1) (B), such hospital shall be allowed
24 increased total revenue for purposes of this title for such
25 accounting year and all subsequent accounting years (and the

1 limit on its allowable rate of increase in inpatient hospital
2 revenues shall be adjusted upward accordingly) in an
3 amount no greater than the amount necessary to maintain
4 the current ratio of its assets to liabilities (determined in
5 accordance with the last sentence of subsection (a)) at the
6 level specified in subsection (a) (2).

7 (e) (1) Any hospital which is dissatisfied with a deter-
8 mination of the Secretary under this section may obtain a
9 hearing before the Provider Reimbursement Review Board
10 established under section 1878 of the Social Security Act,
11 if the amount in controversy is \$25,000 or more and the
12 request for such hearing is filed within one hundred and
13 eighty days after receipt of the Secretary's determination.

14 (2) For purposes of paragraph (1), the Secretary
15 (notwithstanding section 1878 (h) of the Social Security
16 Act) shall appoint five additional members to the Provider
17 Reimbursement Review Board, following the specifications
18 for expertise applicable to the existing five members. Such
19 five additional members shall constitute the Board for pur-
20 poses of reviewing appeals under this title. All the other
21 provisions of section 1878 of the Social Security Act shall
22 apply except that the Board as so constituted shall be con-
23 sidered as reviewing decisions of the Secretary rather than
24 of a fiscal intermediary, and subsection (b) of such section
25 shall not apply.

ENFORCEMENT

2 SEC. 116. (a) Notwithstanding any provision of title
3 XVIII of the Social Security Act, reimbursement for in-
4 patient hospital services under the program established by
5 that title shall not be payable, on an interim basis or in final
6 settlement, to the extent that it exceeds the applicable limits
7 established under this title.

(b) Notwithstanding any provision of title V or XIX of such Act, payment shall not be required to be made by any State under either such title with respect to any amount paid for inpatient hospital services in excess of the applicable limits established under this title; nor shall payment be made to any State under such title with respect to any amount paid for inpatient hospital services in excess of such limits.

(c) Notwithstanding any other provision of law, receipt by any hospital of payment for inpatient hospital services in excess of the applicable limits established under this title, or payment by any cost payer (as defined in section 122 (e) (2)) for inpatient hospital services on a cost basis in excess of such limits, shall subject such hospital or cost payer—

(1) to the Federal excise tax imposed by section 4991 of the Internal Revenue Code of 1954 (as added by section 128 of this Act), and

1 (2) to exclusion, at the discretion of the Secretary,
2 from participation in any or all of the programs estab-
3 lished by titles V, XVIII, and XIX of the Social Secu-
4 rity Act.

5 (d) (1) Where the Secretary determines that average
6 charges per admission billed for inpatient services by a hos-
7 pital during an accounting year any part of which is included
8 in a period subject to this title exceed the applicable limits
9 established under this title, he shall promulgate (or shall
10 require the hospital to promulgate in such manner as he may
11 prescribe) the percentage by which the average charge per
12 admission billed in that accounting year by the hospital ex-
13 ceeded the applicable limitation on average charges per ad-
14 mission established under this title.

15 (2) Any hospital described in paragraph (1) shall be
16 exempt from the penalties set forth in subsection (c) if it
17 holds in escrow an amount equal to the percentage promul-
18 gated under such paragraph multiplied by the hospital's
19 total inpatient charges less its inpatient charges applicable
20 to cost payers (as defined in section 122 (e)), imposed on
21 the accounting year referred to in such paragraph, until such
22 time as charges below the applicable limits established under
23 this title, equal in aggregate to such amount, are experi-
24 enced; but any such hospital which fails to do so shall be
25 subject to such penalties.

1 EXEMPTION FOR HOSPITALS IN CERTAIN STATES

2 SEC. 117. (a) At the request of the Governor (or other
3 chief executive) of any State (including the District of Co-
4 lumbia and Puerto Rico) the Secretary may exclude from
5 the application of this title all hospitals physically located
6 in such State if the Secretary finds that—

7 (1) such State has had in effect for at least one
8 year as of the date of such request a program for con-
9 taining hospital costs in the State which covers at least
10 90 per centum of the hospitals in the State which would
11 otherwise be covered under the program established by
12 this title;

13 (2) the State program applies at least to all in-
14 patient care revenues of such hospitals (except revenues
15 received under title XVIII of the Social Security Act) ;

16 (3) the Governor (or chief executive) certifies,
17 and the Secretary determines, that the aggregate rate of
18 increase in inpatient hospital revenues for all hospitals
19 in the State will not exceed the rate promulgated by the
20 Secretary under section 112 (b) ; and

21 (4) the Governor (or chief executive) has submit-
22 ted, and had approved by the Secretary, a plan for re-
23 covering any excess of revenue which (notwithstanding
24 paragraph (3)) may occur.

25 (b) A State which would meet the conditions of this

1 section except that its program does not satisfy subsection
 2 (a) (2), but whose program did cover at least 50 per centum
 3 of all inpatient care revenues during the twelve-month pe-
 4 riod preceding the date of its request under subsection (a),
 5 will nonetheless be eligible under this section if, by the date
 6 of such request, it does have a program which satisfies such
 7 subsection.

8 EXEMPTION FOR HOSPITALS ENGAGED IN CERTAIN

9 EXPERIMENTS OR DEMONSTRATIONS

10 SEC. 118. A hospital may be excluded from the applica-
 11 tion of this title if the Secretary determines that (1) such
 12 exclusion is necessary to facilitate an experiment or demon-
 13 stration entered into under section 402 of the Social Security
 14 Amendments of 1967 or section 222 of the Social Security
 15 Amendments of 1972, and (2) such experiment or demon-
 16 stration is consistent with the purposes of this title.

17 PART C—DEFINITIONS AND MISCELLANEOUS

18 PROVISIONS

19 DEFINITION OF HOSPITAL

20 SEC. 121. (a) For purposes of this title (subject to sub-
 21 section (b) of this section), the term "hospital", with re-
 22 spect to any accounting year, means an institution (including
 23 a distinct part of an institution participating in the program
 24 established under title XVIII of the Social Security Act)
 25 which—

1 (1) satisfies paragraphs (1) and (7) of section
2 1861 (e) of the Social Security Act, and

3 (2) had an average duration of stay of thirty days
4 or less in the preceding accounting year.

5 (b) An institution shall not be considered a "hospital"
6 during any part of a period subject to this title if with respect
7 to such period it—

8 (1) is a Federal hospital;

9 (2) has met the conditions specified in subsection
10 (a) (under present and previous ownership) for less
11 than two years before such period; or

12 (3) derived more than 75 per centum of its in-
13 patient care revenues on a capitation basis, disregarding
14 revenues received under title XVIII of the Social Se-
15 curity Act, from one or more health maintenance or-
16 ganizations (as defined in section 1301 (a) of the Public
17 Health Service Act).

18 OTHER DEFINITIONS

19 SEC. 122. For purposes of this title—

20 Accounting Year

21 (a) The term "accounting year" with respect to any
22 period means—

23 (1) in the case of a hospital participating in the
24 program established by title XVIII of the Social Se-
25 curity Act, a period of twelve consecutive full calendar

1 months including the same months as the last full re-
2 porting period allowed for reimbursement purposes
3 under such title;

4 (2) in the case of a hospital not participating in
5 the program established by title XVIII of the Social
6 Security Act, a period of twelve consecutive full calen-
7 dar months including the same months as the last full ac-
8 counting period used by such other cost payer as the
9 Secretary may designate; and

10 (3) in the case of a hospital which is not partici-
11 pating in the program established by title XVIII of the
12 Social Security Act and for which the Secretary does
13 not designate an accounting year under paragraph (2),
14 a calendar year.

15 Inpatient Hospital Services

16 (b) The term "inpatient hospital services" has the
17 meaning given it by section 1861 (b) of the Social Security
18 Act (including in addition the services otherwise excluded
19 by paragraph (5) thereof).

20 Inpatient Charges

21 (c) The term "inpatient charges" means regular rates,
22 applied to all inpatient hospital services, that meet the re-
23 quirements of section 405.452 (d) (4) of the Federal regula-
24 tions applicable to title XVIII of the Social Security Act.

Admissions

(d) The term "admission" means the formal acceptance of an inpatient by a hospital, excluding newborn children (unless retained after discharge of the mother) and transfers within inpatient units of the same institution.

Cost Payer

(e) The term "cost payer" means—

(1) a program established by or under title V, XVIII, or XIX of the Social Security Act, and

(2) any organization which (A) meets the definition contained in section 1842 (f) (i) of the Social Security Act, and (B) reimburses a hospital subject to this title for inpatient hospital services on the basis of cost as defined for purposes of such reimbursement.

DETERMINATION OF INPATIENT REIMBURSEMENT

SEC. 123. For purposes of section 111, inpatient reimbursement under the programs establish by titles V, XVIII, and XIX of the Social Security Act shall be determined without regard to adjustments resulting from the application of section 405.460 (g), 405.455 (d), 405.415 (f), or 405.415 (d) (3) of the Federal regulations applicable to such title XVIII.

EXEMPTION OF NONSUPERVISORY PERSONNEL WAGE

INCREASES FROM REVENUE LIMIT

SEC. 124. (a) At the request of any hospital which is subject to the provisions of this title and which provides the

1 data necessary for the required calculation, the Secretary shall
2 modify the inpatient hospital revenue increase limit and the
3 adjusted inpatient hospital revenue increase limit otherwise
4 established for such hospital with respect to any accounting
5 year under section 112 to allow such hospital to receive,
6 without restriction, revenue equal to the average amount of
7 any increase in regular wages granted in such year to em-
8 ployees who do not meet the definition of "supervisor" as that
9 term is used for purposes of the National Labor Relations Act
10 and (if not employees of a State or political subdivision
11 thereof) who are covered by such Act.

12 (b) Such modified limits for any accounting year shall
13 be calculated by adding together—

14 (1) the average percentage increase in regular
15 wages granted to the employees referred to in subsec-
16 tion (a) since the close of the preceding accounting year
17 multiplied by the percentage of total inpatient cost (as
18 determined for purposes of title XVIII of the Social
19 Security Act) attributable to such wages in such preced-
20 ing year; and

21 (2) the inpatient hospital revenue increase limit
22 or, as appropriate, the adjusted inpatient hospital reve-
23 nue increase limit otherwise applicable to the hospital
24 under this title multiplied by the percentage of revenues
25 (as determined for purposes of title XVIII of the Social

1 Security Act) attributable to all other expenses in the
2 preceding accounting year.

3 (c) The modified inpatient hospital revenue increase
4 limit and adjusted inpatient hospital revenue increase limit
5 established under subsection (b) for any hospital with re-
6 spect to any accounting year shall constitute such hospital's
7 inpatient hospital revenue increase limit or, as appropriate,
8 the adjusted inpatient hospital revenue increase limit for
9 such year under section 111 for all of the purposes of this
10 title.

11 (d) This section shall apply to accounting years begin-
12 ning after March 31, 1979, only to the extent the Secretar
13 so determines.

14 DISCLOSURE OF FISCAL INFORMATION

15 SEC. 125. (a) (1) Every hospital shall (A) submit
16 semiannually to the health systems agency designated under
17 section 1515 of the Public Health Service Act for the health
18 service area in which it is located, by March 1 and Sep-
19 tember 1 of each year, its average semiprivate room rate
20 and the charges for the ten other services which the health
21 systems agency finds represent the services which are most
22 frequently used or most important for purposes of compar-
23 ing hospitals, and make available all cost reports submitted
24 to cost payers, and (B) submit annually its overall plan

1 and budget described in section 1864(z) of the Social
2 Security Act.

3 (2) Failure by any hospital to comply with the re-
4 quirement of paragraph (1) shall subject it to exclusion,
5 at the discretion of the Secretary, from participation in any
6 or all of the programs established by titles V, XVIII, and
7 XIX of the Social Security Act.

8 (b) Each health systems agency designated under
9 section 1515 of the Public Health Service Act shall publish
10 every April 1 and October 1, in readily understandable lan-
11 guage for public use, the information it receives under this
12 section, in a manner designed to facilitate comparisons
13 among the hospitals in its area.

14 IMPROPER CHANGES IN ADMISSION PRACTICES

15 SEC. 126. Upon written complaint by any institution
16 meeting the conditions set forth in paragraphs (1) and (7)
17 of section 1861(e) of the Social Security Act that one or
18 more hospitals subject to this title in a health service area
19 for which a health systems agency has been designated un-
20 der section 1515 of the Public Health Service Act has
21 changed its admission practices in a manner that would
22 tend to reduce the proportion of inpatients of such hospital
23 or hospitals for whom reimbursement at less than the in-
24 patient charges (as defined in section 122(c) of this Act)
25 applicable to such inpatients is anticipated, such health sys-

1 tems agency shall investigate the complaint and, upon a
 2 finding by such agency that the complaint is justified, the
 3 Secretary may impose the sanction set forth in section 116
 4 (c) (2) of this Act.

5 REVIEW OF CERTAIN DETERMINATIONS

6 SEC. 127. Any determinations made on behalf of the
 7 Secretary under this title with respect to the application of
 8 its provisions to individual hospitals (other than determina-
 9 tions made under section 115 or 126) shall be subject to the
 10 provisions of section 1878 of the Social Security Act in the
 11 same manner as determinations with respect to the amount
 12 of reimbursement due a provider of services under title
 13 XVIII of such Act.

14 EXCISE TAX ON EXCESSIVE PAYMENTS FOR INPATIENT
 15 HOSPITAL SERVICES

16 SEC. 128. (a) Subtitle D of the Internal Revenue Code
 17 of 1954 (relating to miscellaneous excise taxes) is amended
 18 by adding at the end thereof the following new chapter:

19 **“CHAPTER 45—TAX ON CERTAIN EXCES-**
 20 **SIVE PAYMENTS FOR INPATIENT HOS-**
 21 **PITAL SERVICES**

 “Sec. 4991. Imposition of tax.

22 **“SEC. 4991. IMPOSITION OF TAX.**

23 “(a) IN GENERAL.—There is hereby imposed, with re-
 24 spect to the receipt by any hospital of payment for inpatient

1 hospital services in excess of the applicable limits established
 2 by title I of the Hospital Cost Containment Act of 1977, and
 3 with respect to any payment made by any cost payer as de-
 4 fined in section 122 (e) (2) of such Act for inpatient hospital
 5 services on a cost basis in excess of such limits, a tax equal
 6 to 150 percent of the amount of such excess. The tax im-
 7 posed by this subsection shall be paid by the hospital or cost
 8 payer.

9 “(b) EXCEPTION.—The tax imposed by subsection (a)
 10 shall not apply with respect to any hospital so long as it is
 11 determined by the Secretary of Health, Education, and Wel-
 12 fare to be taking the corrective action described in section
 13 116(d) (2) of the Hospital Cost Containment Act of 1977.

14 “(c) DEFINITIONS.—Terms used in subsections (a)
 15 and (b) have the meanings given them by title I of the Hos-
 16 pital Cost Containment Act of 1977.

17 “(d) ADMINISTRATION.—Under and to the extent pro-
 18 vided by regulations of the Secretary, the appropriate provi-
 19 sions of subtitle F (relating to procedure and administra-
 20 tion) shall be made applicable with respect to the tax im-
 21 posed by subsection (a) of this section.”.

22 (b) The table of chapters for subtitle D of such Code
 23 is amended by adding at the end thereof the following new
 24 item:

“Chapter 45. Tax on Certain Excessive Payments for In-
 patient Hospital Services.”.

1 TITLE II—LIMITATION ON HOSPITAL CAPITAL
2 EXPENDITURES

3 SEC. 201. (a) Part A of title XV of the Public Health
4 Service Act is amended by adding at the end thereof the
5 following new section:

6 "LIMITATION ON HOSPITAL CAPITAL EXPENDITURES,
7 CEILING FOR THE SUPPLY OF HOSPITAL BEDS, AND
8 STANDARDS FOR OCCUPANCY OF HOSPITAL BEDS

9 "SEC. 1504. (a) (1) Before the beginning of the fiscal
10 year beginning October 1, 1977, and at least sixty days
11 before the beginning of each succeeding fiscal year, the
12 Secretary shall promulgate a sum as a hospital capital ex-
13 penditure limit applicable to such fiscal year. The sum pro-
14 mulgated as a limit under the preceding sentence for any
15 period shall be an amount which may not exceed \$2,500-
16 000,000.

17 "(2) The Secretary shall apportion the sum promul-
18 gated under paragraph (1) for any fiscal year among the
19 various States on the basis of the population of the various
20 States; except that for any fiscal year beginning more than
21 eighteen months after the date of enactment of this section
22 the Secretary shall apportion the sum promulgated under
23 paragraph (1) for such fiscal year among the various
24 States, taking into account the population of the various
25 States; and also taking into account, to the extent feasible,

1 variations among the States in the costs of construction,
 2 population patterns and growth, the need for hospital fa-
 3 cilities and equipment and for modernization of existing
 4 hospital facilities and equipment, and other factors important
 5 to the equitable apportionment of such sum.

6 “(b) (1) At the time the Secretary promulgates under
 7 subsection (a) a hospital capital expenditure limit the Sec-
 8 retary shall also promulgate for the fiscal year to which such
 9 limit is applicable—

10 “(A) a national ceiling for the supply of hospital
 11 beds within health service areas established under sec-
 12 tion 1511 (hereinafter in this title referred to as the
 13 ‘supply ceiling’), and

14 “(B) a national standard for the rate of occupancy
 15 of hospital beds within such areas (hereinafter in this
 16 title referred to as the ‘occupancy standard’).

17 “(2) The supply ceiling promulgated for any fiscal
 18 year under paragraph (1) (A) may not exceed the ratio of
 19 four hospital beds per one thousand of population; but the
 20 Secretary may promulgate under such paragraph a different
 21 supply ceiling for health service areas which have special
 22 characteristics or which meet special requirements estab-
 23 lished by the Secretary.

24 “(3) The occupancy standard promulgated under para-
 25 graph (1) (B) for any fiscal year may not be less than 80

1 per centum; but the Secretary may establish a different oc-
2 cupancy standard for health service areas which have special
3 characteristics or which meet special requirements estab-
4 lished by the Secretary.”.

5 (b) (1) Part C of title XV of the Public Health Service
6 Act is amended by adding at the end thereof the following
7 new section:

8 “CERTIFICATE OF NEED PROGRAM

9 “SEC. 1527. (a) The certificate of need program re-
10 quired by section 1523 (a) (4) (B) shall provide for the
11 following:

12 “(1) Review and determination of need under such
13 program of institutional health services, health care facilities,
14 and health maintenance organizations shall be made before
15 the time such services, facilities, and organizations are offered
16 or developed or substantial expenditures are undertaken in
17 preparation for such offering or development.

18 “(2) The Program shall be administered in such a man-
19 ner that only those services, facilities, and organizations
20 found to be needed shall be offered or developed in the State
21 in which the program applies.

22 “(3) In issuing a certificate of need for any such serv-
23 ice, facility, or organization, the State shall specify in the
24 certificate the maximum amount of capital expenditures

1 which may be made for such service, facility, or organization
2 under such certificate.

3 “(4) The aggregate of the maximum amounts of capi-
4 tal expenditures authorized in a fiscal year in accordance
5 with paragraph (3) for hospitals may not exceed the por-
6 tion of the sum promulgated under section 1504 (a) (1)
7 and apportioned to the State under section 1504 (a) (2)
8 for such fiscal year, as adjusted in accordance with this para-
9 graph. For any fiscal year the sum apportioned to a State
10 under section 1504 (a) (2) shall (A) if the aggregate of the
11 maximum amounts of capital expenditures authorized by the
12 State in the preceding fiscal year in accordance with para-
13 graph (3) for hospitals was less than the portion of such
14 sum so apportioned to the State for such fiscal year, the dif-
15 ference between such authorized maximum amounts and the
16 sum so apportioned shall be added to the sum so apportioned
17 to the State for the fiscal year following such fiscal year,
18 and (B) if in the fiscal year there was a closure of a hospital
19 (or part thereof) through which institutional health services
20 found under section 1523 (a) (6) to be inappropriate were
21 provided, then the amount by which the historical cost (as
22 defined for purposes of title XVIII of the Social Security
23 Act) of such hospital or part exceeds the total amount of
24 depreciation of such hospital or part claimed for purposes of
25 establishing the reasonable costs of services provided by the

1 hospital for purposes of receiving reimbursement under title
2 XVIII of the Social Security Act shall be added to the por-
3 tion of such sum so apportioned to the State for such fiscal
4 year.

5 “(b) (1) Under such a certificate of need program a
6 certificate of need may not, except as provided in paragraph
7 (2), be granted for an institutional health service or health
8 care facility within a health service area established under
9 section 1511 if the development of such service or facility
10 under such certificate would result in a number of hospital
11 beds within such area which is in excess of the applicable
12 supply ceiling promulgated under section 1504 (b) (1) (A).

13 “(2) If in a health service area the number of hospital
14 beds is in excess of the supply ceiling applicable to a fiscal
15 year, then a certificate of need may be granted for such a
16 service or facility the development of which would result in
17 a number of new hospital beds which is not more than one-
18 half of the number of hospital beds removed permanently
19 from service in such area in such fiscal year. The amount
20 by which the number of new hospital beds with respect to
21 which certificates of need may be issued in a fiscal year under
22 the preceding sentence is less than the number of new hos-
23 pital beds with respect to which certificates of need were is-
24 sued in such fiscal year may be added to the number of new

1 hospital beds with respect to which certificates of need may
2 be issued in the succeeding fiscal year.

3 “(c) (1) Under such certificate of need program a
4 certificate of need may not, except as provided in paragraph
5 (2), be granted for an institutional health service or health
6 care facility within a health service area if the development
7 of such service or facility could reasonably be expected to
8 produce a number of hospital beds which would result in a
9 hospital bed occupancy rate within such area which is less
10 than the applicable occupancy standard promulgated under
11 section 1504 (b) (1) (B).

12 “(2) If in any fiscal year the hospital bed occupancy
13 rate within a health service area is less than the occupancy
14 standard applicable for such fiscal year, then a certificate of
15 need may be granted for a service or facility the development
16 of which would result in a number of new hospital beds
17 which is not more than one-half of the number of hospital
18 beds removed permanently from service in such area in
19 such fiscal year. The amount by which the number of new
20 hospital beds with respect to which certificates of need may
21 be issued in a fiscal year under the preceding sentence is less
22 than the number of new hospital beds with respect to which
23 certificates of need were issued in such fiscal year may be
24 added to the number of new hospital beds with respect to

1 which certificates of need may be issued in the succeeding
2 fiscal year.

3 “(d) In granting certificates of need under such a pro-
4 gram a State shall take into account priorities recommended
5 by health systems agencies within the State under section
6 1513 (h).”.

7 (2) The second sentence of section 1523 (a) (4) of the
8 Public Health Service Act is repealed.

9 (c) Section 1531 of the Public Health Service Act is
10 amended (1) by striking out “For purposes of this title”
11 and inserting in lieu thereof, “Except as otherwise provided
12 for purposes of this title”, and (2) by adding after para-
13 graph (5) the following new paragraphs:

14 “(6) For purposes of sections 1504 and 1527, the
15 term ‘hospital’, with respect to any accounting year, means
16 an institution (including a distinct part of an institution par-
17 ticipating in the program established under title XVIII of
18 the Social Security Act) which—

19 “(A) satisfies paragraphs (1) and (7) of section
20 1861 (e) of the Social Security Act, and

21 “(B) has an average duration of stay of thirty days
22 or less in the preceding accounting year,

23 except that for any fiscal year such term does not include a
24 Federal hospital or an institution which during such fiscal
25 year derived more than 75 per centum of its inpatient care

1 revenues on a capitation basis, disregarding revenues re-
2 ceived under title XVIII of the Social Security Act, from
3 one or more health maintenance organizations (as defined
4 in section 1301 (a)).

5 “(7) For the purposes of sections 1504 and 1527, the
6 term ‘capital expenditure’ means an expenditure which, un-
7 der generally accepted accounting principles, is not prop-
8 erly chargeable as an expense of operation and maintenance
9 and which (A) exceeds \$100,000, (B) changes the bed
10 capacity of the facility with respect to which such expendi-
11 ture is made, or (C) substantially changes the services of the
12 facility with respect to which such expenditure is made, ex-
13 cept that such term includes expenditures for obtaining a
14 facility or part thereof, or equipment for a facility or part,
15 under a lease or comparable arrangement but does not in-
16 clude the acquisition of an existing hospital facility if such ac-
17 quisition does not make a change in the services or bed ca-
18 pacity of such hospital facility. For purposes of clause (A)
19 of the preceding sentence, the cost of the studies, surveys,
20 design, plans, working drawings, specifications, and other
21 activities essential to the acquisition, improvement, expan-
22 sion, replacement of the plant and equipment with respect
23 to which such expenditure is made shall be included in de-
24 termining whether such expenditure exceeds \$100,000. If
25 a person makes an acquisition of equipment for a hospital and

1 donates it to the hospital, the expenditure for such acquisi-
 2 tion shall be considered a hospital capital expenditure for
 3 purposes of section 1504 and 1527.”.

4 (d) Section 1532 (b) (2) of the Public Health Service
 5 Act is amended (1) by striking out “ninety days” and in-
 6 serting in lieu thereof “one year”, and (2) by adding be-
 7 fore the period “or longer than such shorter period from
 8 such date as the Secretary may prescribe”.

9 SEC. 202. (a) (1) Section 1122 of the Social Security
 10 Act is amended by adding at the end thereof the following
 11 new subsection:

12 “(j) (1) Except as provided in paragraph (2), in de-
 13 termining the Federal payments to be made under titles V,
 14 XVIII, and XIX with respect to services furnished in a
 15 health care facility located in a State—

16 “(A) which has not entered into an agreement
 17 with the Secretary under this section, or

18 “(B) which does not have a certificate of need pro-
 19 gram approved under title XV of the Public Health
 20 Service Act,

21 the Secretary shall not include an amount equal to ten times
 22 any amount which is attributable to depreciation, interest
 23 on borrowed funds, and return on equity capital (in the case
 24 of proprietary facilities) or other expenses related to capital
 25 expenditures after September 30, 1977, for such health care

1 facility unless the Secretary has approved, in accordance
2 with procedures and criteria established by the Secretary,
3 such expenditures after taking into account any recom-
4 mendation made by a State agency designated under section
5 1521 of the Public Health Service Act. With respect to any
6 organization which is reimbursed on a per capita or a fixed
7 fee or negotiated rate basis, in determining the Federal pay-
8 ments to be made under titles V, XVIII, and XIX, the
9 Secretary shall exclude an amount which in his judgment
10 is a reasonable equivalent to the amount which would other-
11 wise be excluded under this subsection if payment were to
12 be made on other than a per capita or a fixed fee or negoti-
13 ated rate basis.

14 “(2) Paragraph (1) shall not apply with respect to de-
15 termination of Federal payments to be made under title V,
16 XVIII, or XIX with respect to services furnished in a health
17 care facility located in a State which has a certificate of need
18 program, approved by the Secretary for purposes of this
19 section, which applies to capital expenditures for hospitals
20 and with respect to which such capital expenditures meet
21 the requirements of section 1527 of the Public Health Serv-
22 ice Act.”.

23 (2) Subsection (e) of such section 1122 is amended
24 by striking out “subsection (d)” and inserting in lieu there-
25 of “subsection (d) or (j)”.

1 (3) Subsection (b) of such section 1122 is amended
2 by inserting before the period at the end thereof the follow-
3 ing: "or does not meet any applicable requirement of sub-
4 section (a) (4), (b), or (c) of section 1527 of the Public
5 Health Service Act".

6 (4) Subsection (d) (1) of such section 1122 is
7 amended by striking out "any amount" in the matter follow-
8 ing subparagraph (B) of the first sentence of such section
9 and inserting in lieu thereof "an amount equal to ten times
10 any amount".

11 (b) The amendments made by subsection (a) shall
12 apply with respect to capital expenditures made after Sep-
13 tember 30, 1977.

14 SEC. 203. (a) Section 103 of the Internal Revenue
15 Code of 1954 (relating to exclusion from gross income of
16 interest on certain governmental obligations) is amended by
17 redesignating subsection (f) as subsection (g), and by in-
18 serting after subsection (e) the following new subsection:

19 “(f) OBLIGATIONS SUPPORTING INCREASES IN ACUTE
20 CARE HOSPITAL BEDS.—Any obligation issued by a State
21 or territory for an institutional health service, health care
22 facility, or health maintenance organization—

23 “(1) the development of which would result in a
24 number of hospital beds within a health service area
25 which number is in excess of the applicable supply ceil-

1 ing for such area promulgated under section 1504 (b)

2 (1) (A) of the Public Health Service Act, or

3 “(2) for which a certificate of need has not been

4 issued under a certificate of need program approved

5 under title XV of the Public Health Service Act,

6 shall be treated as an obligation not described in subsection

7 (a) (1).”.

8 (b) The amendments made by subsection (a) shall ap-

9 ply with respect to taxable years beginning after the date

10 of the enactment of this Act.

95TH CONGRESS
1ST SESSION

S. 1470

IN THE SENATE OF THE UNITED STATES

MAY 5 (legislative day, APRIL 28), 1977

Mr. TALMADGE (for himself, Mr. LONG, Mr. RIBICOFF, Mr. DOLE, Mr. NUNN, Mr. EASTLAND, Mr. MATSUNAGA, Mr. RANDOLPH, Mr. HOLLINGS, Mr. INOUE, Mr. GRAVEL, Mr. FORD, Mr. JAVITS, Mr. PELL, Mr. PERCY, Mr. BROOKE, Mr. BURDICK, Mr. STONE, Mr. METZENBAUM, and Mr. HATHAWAY) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs, and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*
- 3 That this Act may be cited as the "Medicare-Medicaid
- 4 Administrative and Reimbursement Reform Act".

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Sec. 10. Agreement by physicians to accept assignments.
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2 HOSPITAL SERVICES

98-772 O - 78 - 4

1 “(8) For additional requirements applicable to deter-
2 mination of reasonable cost for services provided by hos-
3 pitals, see subsection (aa).”.

4 (b) Section 1861 of the Act is amended by adding
5 after subsection (z) the following subsection:

6 "CRITERIA FOR DETERMINING REASONABLE COST OF
7 HOSPITAL SERVICES

8 “(aa) (1) To more fairly and effectively determine
9 reasonable costs incurred in providing hospital services, the
10 Secretary shall, not later than April 1, 1978, after consult-
11 ing with appropriate national organizations, establish—

12 “(A) an accounting and uniform functional cost
13 reporting system (including uniform procedures for al-
14 location of costs) for determining operating and capi-
15 tal costs of hospitals providing services, and

16 “(B) a system of hospital classification under
17 which hospitals furnishing services will initially be clas-
18 sified as follows:

19 “(i) by size, with each of the following groups
20 of hospitals being classified in separate categories:

21 (I) those having more than 5, but fewer than
22 25, beds, (II) those having more than 24, but
23 fewer than 50, beds, (III) those having more than
24 49, but fewer than 100, beds, (IV) those having
25 more than 99, but fewer than 200, beds, (V)

1 those having more than 199, but fewer than 300,
2 beds, (VI) those having more than 299, but fewer
3 than 400, beds, (VII) those having more than
4 399, but fewer than 500, beds, and (VIII) those
5 having more than 499 beds,

6 “(ii) by type of hospital, with (I) short-
7 term general hospitals being in a separate category,
8 (II) hospitals which are the primary affiliates of
9 accredited medical schools (with one hospital to
10 be nominated by each accredited medical school)
11 being in one separate category (without regard to
12 bed size), and (III) psychiatric, geriatric, mater-
13 nity, pediatric, or other specialty hospitals being in
14 the same or separate categories, as the Secretary
15 may determine appropriate, in light of any differ-
16 ences in specialty which significantly affect the rou-
17 tine costs of the different types of hospitals, and

18 “(iii) other criteria which the Secretary may
19 find appropriate, including modification of bed-size
20 categories;

21 but the system of hospital classification shall not differ-
22 entiate between hospitals on the basis of ownership.

23 “(2) The term ‘routine operating costs’ used in this
24 subsection does not include:

25 “(A) capital and related costs,

1 “(B) direct personnel and supply costs of hospital
2 education and training programs,

3 “(C) costs of interns, residents, and non-adminis-
4 trative physicians,

5 “(D) energy costs associated with heating and
6 cooling the hospital plant, and

7 “(E) malpractice insurance expense, or,

8 “(F) ancillary service costs.

9 “(3) (A) During the calendar quarter beginning on
10 January 1 of each year, beginning with 1979, the Secretary
11 shall determine, for the hospitals in each category of the
12 system established under paragraph (1) (B), an average
13 per diem routine operating cost amount which shall (except
14 as otherwise provided in this subsection) be used in deter-
15 mining payments to hospitals.

16 “(B) The determination shall be based upon the amount
17 of the hospitals' routine operating costs for the preceding
18 fiscal year.

19 “(C) In making a determination, the routine operating
20 costs of each hospital shall be divided into personnel and
21 nonpersonnel components.

22 “(D) (i) The personnel and nonpersonnel components
23 of routine operating costs for each of the hospitals (other
24 than for those excluded under clause (ii)) in each
25 category shall be added for all hospitals and then divided

1 by the total number of days of routine care provided by the
2 hospitals in the category to determine the average per diem
3 routine operating cost for each category.

4 “(ii) In making the calculations required by clause
5 (i), the Secretary shall exclude any hospital which has sig-
6 nificant understaffing problems or which otherwise experi-
7 ences significant cost differentials resulting from failure of
8 the hospital to fully meet the standards and conditions of
9 participation as a provider of services as determined by the
10 Secretary.

11 “(E) There shall be determined for each hospital in
12 each category a per diem payment rate for routine operating
13 costs. That payment rate shall equal the average per diem
14 routine operating cost amount for the category in which
15 the hospital is expected to be classified during the subsequent
16 fiscal year, except that the personnel component shall be
17 adjusted using a wage index based upon general wage levels
18 (including fringe benefit costs) in the areas in which the
19 hospitals are located. If the Secretary finds that, in an area
20 where one or more hospitals in any category are located,
21 for the fiscal year ending June 30, 1977, the wage level
22 (including fringe benefit costs) for hospitals is significantly
23 higher than the general wage level (including fringe bene-
24 fit costs) in that area (relative to the relationship between
25 hospital wages and general wages in other areas), then

1 the general wage level in the area shall be deemed equal
2 to the wage level for hospitals in that area, but only during
3 fiscal year 1979.

4 “(4) (A) (i) The term ‘adjusted per diem payment rate
5 for routine operating costs’, means the per diem payment rate
6 for routine operating costs plus the average percentage
7 increase in prices determined under succeeding provisions
8 of this subparagraph.

9 “(ii) In making payments for services, the Secretary
10 shall add a semiannual average percentage increase in the
11 cost of the mix of goods and services (including personnel
12 and nonpersonnel costs) comprising routine operating costs,
13 equal to the lesser of: (I) the average percentage increase
14 estimated by the hospital, or (II) the average percentage
15 increase in the area estimated by the Secretary.

16 “(iii) At the end of the fiscal year, the amounts paid
17 under clause (ii) shall be adjusted to reflect the lesser of
18 (I) the actual cost increase experienced by the hospital
19 or (II) the actual increase in costs which occurred in the
20 mix of goods and services in the area. Adjustments shall also
21 be made to take account of unexpected changes in the hos-
22 pital’s classification.

23 “(B) For purposes of payment the amount of routine
24 operating cost incurred by a hospital shall be deemed to
25 equal—

1 “(i) for a hospital which has actual routine oper-
2 ating costs equal to or greater than that hospital’s
3 adjusted per diem payment rate for routine operating
4 costs, an amount equal to the greater of:

5 “(I) The hospital’s actual routine operating
6 costs, but not exceeding 120 percent of the hos-
7 pital’s adjusted per diem payment rate for routine
8 operating costs, or

9 “(II) the amounts determined for the hospital
10 under clause (I) if it had been classified in the
11 bed-size category nearest to the category in which
12 the hospital was classified, but not exceeding the
13 hospital’s actual routine operating costs; and

14 “(ii) for a hospital which has actual routine operating
15 costs less than that hospital’s adjusted per diem pay-
16 ment rate for routine operating costs, an amount equal
17 to (I) the amount of the hospital’s actual routine op-
18 erating costs, plus (II) whichever is smaller: (a) 5
19 percent of the hospital’s adjusted per diem payment
20 rate for routine operating costs, or (b) 50 percent of
21 the amount by which the hospital’s adjusted per diem
22 payment rate for routine operating costs exceeds the
23 hospital’s actual routine operating costs.

24 “(C) Any hospital excluded by the Secretary under
25 paragraph (3) (D) (ii), shall be reimbursed for routine

1 operating costs the lesser of (i) actual costs or (ii) the
2 reimbursement determined under this subsection.

3 “(D) April 1 of the year in which the Secretary deter-
4 mines the amount of the average per diem operating cost for
5 each hospital category and the adjusted per diem payment
6 rate for each hospital, the determinations shall be published
7 by the Secretary; and the Secretary shall notify the hospital
8 administrator and the administrative governing body of each
9 hospital with respect to all aspects of the determination
10 which affect the hospital.

11 “(E) If a hospital is determined by the Secretary to
12 be—

13 “(i) located in an underserved area where hospital
14 services are not otherwise available,

15 “(ii) certified as being currently necessary by an
16 appropriate planning agency, and

17 “(iii) underutilized,

18 the adjusted per diem payment rate shall not apply to
19 that portion of the hospital's routine operating costs attrib-
20 utable to the underutilized capacity.

21 “(F) If a hospital satisfactorily demonstrates to the
22 Secretary that, in the aggregate, its patients require a sub-
23 stantially greater intensity of care than is generally provided
24 by the other hospitals in the same category, resulting in

10

1 unusually greater routine operating costs, then the adjusted
2 per diem payment rate shall not apply to that portion of
3 the hospital's routine operating costs attributable to the
4 greater intensity of care required.

5 “(G) The Secretary may further increase the adjusted
6 per diem payment rate to reflect the higher prices prevailing
7 in Alaska or Hawaii.

8 “(H) Where the Secretary finds that a hospital has
9 manipulated its patient mix, or patient flow, or provides less
10 than the normal range and extent of patient service, or where
11 an unusually large proportion of routine nursing service is
12 provided by private-duty nurses, the routine operating costs
13 of that hospital shall be deemed equal to whichever is less:
14 the amount determined without regard to this subsection,
15 or the amount determined under subparagraph (B).

16 “(5) Where any provisions of this subsection are in-
17 consistent with section 1861 (v), this subsection supersedes
18 section 1861 (v).”

19 (c) (1) The Secretary shall, at the earliest practical
20 date, develop additional methods for reimbursing hospitals
21 for all other costs, and for reimbursing all other entities
22 which are reimbursed on the basis of reasonable cost. Those
23 methods shall provide appropriate classification and reim-
24 bursement systems designed to ordinarily permit comparisons
25 of the cost centers of one entity, either individually or in

1 the aggregate, with cost centers similar in terms of size
2 and scale of operation, prevailing wage levels, nature, ex-
3 tent, and appropriate volume of the services furnished, and
4 other factors which have a substantial impact on hospital
5 costs. The Secretary shall provide procedures for appropriate
6 exceptions.

7 (2) The systems of reimbursement shall not permit
8 payment for costs which exceed 120 percent of the average
9 cost incurred by other institutions or agencies in the same
10 class, unless an exception has been allowed.

11 (3) The Secretary shall, as classification and reimburse-
12 ment systems methods are developed, but not later than two
13 years from enactment, submit appropriate legislative recom-
14 mendations to the Congress.

15 (d) The provisions of section 1861(aa) (2), (3),
16 and (4) of the Social Security Act—

17 (1) shall apply for informational purposes for
18 services furnished by a hospital before October 1, 1979;
19 and

20 (2) shall be effective for fiscal years beginning
21 with fiscal year 1981.

22 (e) Notwithstanding any other provision of this Act,
23 where the Secretary has entered into a contract with a State,
24 as authorized under section 222 of Public Law 92-603 or
25 section 1533 (d) of the Public Health Service Act, to estab-

lish a reimbursement system for hospitals, hospital reimbursement in that State under titles XVIII and XIX shall be based on that State system, if the Secretary finds that—

(1) the State has mandated the reimbursement system and it applies to all hospitals in the State which have provider agreements under title XVIII or title XIX;

(2) the system applies to all revenue sources for hospital services in the State;

(3) all hospitals in the State with which there is a provider agreement conform to the accounting and uniform reporting requirements of section 1861(aa) (1) (A), and furnishes any appropriate reports that the Secretary may require; and,

(4) (A) based upon an annual evaluation of the system, aggregate payments to hospitals in the State under title XVIII and title XIX for those components of hospitals costs determined under section 1861(aa) for the fiscal year following an annual evaluation are estimated to be less than payments would be under section 1861(aa) or, (B) where a State that is unable to satisfy requirements of subparagraph (A) demonstrates to the satisfaction of the Secretary that total reimbursable inpatient hospital costs in the

13

1 State are lower than would otherwise be payable under
2 title XVIII and title XIX.

3 If the Secretary finds that any of the above conditions
4 in a State which previously met them have not been met
5 for a year the Secretary shall, after due notice, reimburse
6 hospitals in that State according to the provisions of this
7 Act unless he finds that unusual, justifiable and non-
8 recurring circumstances led to the failure to comply.

9 (f) (1) Section 1866 (a) (1) of the Social Security
10 Act is amended by inserting “, and” in place of the period
11 at the end of subparagraph (C), and by adding a subpara-
12 graph: “(D) not to increase amounts due from any indi-
13 vidual, organization, or agency in order to offset reductions
14 made under section 1861 (aa) in the amount paid, or ex-
15 pected to be paid, under title XVIII.”.

16 (2) Section 1902 (a) (27) of the Social Security Act is
17 amended by deleting “and” at the end of subparagraph
18 (A), by inserting “, and” in place of the semicolon at the
19 end of subparagraph (B) and by adding a new subpara-
20 graph:

21 “(C) not to increase amounts due from any individual
22 organization, or agency in order to offset reductions made
23 under section 1902 (a) (13) (D) in the amount paid, or ex-
24 pected to be paid under title XIX;”

1 (h) Section 1902 (a) (13) (D) is amended to read as
2 follows:

3 “(D) for payment of the reasonable cost of inpa-
4 tient hospital services provided under the plan, applying
5 the methods specified in section 1861 (v) and section
6 1861 (aa), which are consistent with section 1122;
7 and”.

8 PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF
9 UNDERUTILIZED FACILITIES

10 SEC. 3. (a) Part A of title XI of the Social Security
11 Act is amended by adding at the end the following new
12 section:

13 “PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF
14 UNDERUTILIZED FACILITIES

15 “SEC. 1132. (a) (1) (A) Before the end of the third
16 full month following the month in which this section is en-
17 acted, the Secretary shall establish a Hospital Transitional
18 Allowance Board (referred to in this section as the ‘Board’).
19 The Board shall have five members, appointed by the Sec-
20 retary without regard to the provisions of title 5, United
21 States Code, governing appointments in the competitive
22 service, who are knowledgeable about hospital planning and
23 hospital operations.

24 “(B) Members of the Board shall be appointed for
25 three-year terms, except some initial members shall be ap-

15

1 pointed for shorter terms to permit staggered terms of office.

2 “(C) Members shall be entitled to per diem compen-
3 sation at rates fixed by the Secretary, but not more than
4 the current per diem equivalent at the time the service in-
5 volved is rendered for grade GS-18 in section 5332 of title
6 5, United States Code.

7 “(D) The Secretary shall provide technical, secretarial,
8 clerical, and other assistance as the Board may need.

9 “(2) The Board shall receive, and act upon applications
10 by hospitals certified for participation (other than as ‘emer-
11 gency hospitals’) under titles XVIII and XIX for transi-
12 tional allowances.

13 “(b) For purposes of this section—

14 “(1) The term ‘transitional allowance’ means an amount
15 which—

16 “(A) shall, solely by reason of this section, be in-
17 cluded in a hospital’s reasonable cost for purposes of cal-
18 culating payments under the programs authorized by
19 titles V, XVIII, and XIX, of this Act; and

20 “(B) in accordance with this section, it is estab-
21 lished by the Secretary for a hospital in recognition of
22 a reimbursement detriment (as defined in paragraph
23 (3)) experienced because of a qualified facility con-
24 version (as defined in paragraph (2)).

25 “(2) The term ‘qualified facility conversion’ means

1 closing, modifying, or changing usage of underutilized hos-
2 pital facilities which is expected to benefit the programs au-
3 thorized under title XVIII and title XIX by (i) eliminating
4 excess bed capacity, (ii) discontinuing an underutilized
5 service for which there are adequate alternative sources, or
6 (iii) substituting for the underutilized service some other
7 service which is needed in the area and which is consistent
8 with the findings of an appropriate health planning agency.

9 “(3) A hospital which has carried out a qualified con-
10 version and which continues in operation will be regarded
11 as having experienced a ‘reimbursement detriment’ (A)
12 to the extent that, solely because of the conversion there is
13 a reduction in the aggregate reimbursement (but only to
14 the extent the capital was accepted as reasonable for pur-
15 poses of reimbursement) which is considered in determining
16 for payment purposes under title XVIII or title XIX to the
17 hospital the reasonable cost (as the term is used for purposes
18 of those titles) incurred by the hospital; (B) if the conver-
19 sion results, on an interim basis, in increased operating costs
20 to the extent that operating costs exceed amounts ordinarily
21 reimbursable under titles XVIII and XIX, or (C) in the
22 case of complete closure of a nonprofit, nongovernmental
23 (except local governmental) hospital, other than for re-
24 placement of the hospital to the extent of actual debt
25 obligations previously recognized as reasonable for reim-

1 bursement, where the debt remains outstanding, less any
2 salvage value.

3 “(c) (1) Any hospital may file an application with the
4 Board (in a form and including data and information as
5 the Board, with the approval of the Secretary, may require)
6 for a transitional allowance with respect to any qualified
7 conversion which was formally initiated after December 31,
8 1977. The Board, with the approval of the Secretary, may
9 also establish procedures, consistent with this section, by
10 means of which a finding of a reimbursement detriment may
11 be made prior to the actual conversion.

12 “(2) The Board shall consider any application filed
13 by a hospital, and if the Board finds that—

14 “(A) the facility conversion is a qualified facility
15 conversion, and

16 “(B) the hospital is experiencing a reimbursement
17 detriment because it carried out the qualified facility
18 conversion,

19 the Board shall transmit to the Secretary its recommendation
20 that the Secretary establish, a transitional allowance for the
21 hospital in amounts reasonably related to prior or prospec-
22 tive use of the facility under titles XVIII and XIX, and for
23 a period, not to exceed twenty years, specified by the Board;
24 and, if the Board finds that the criteria in clauses (A) and
25 (B) are not met, it shall advise the Secretary not to estab-

1 ... a transitional allowance for that hospital. For an ap-
2 proved closure under subsection (b) (3) (C) the Board may
3 recommend or the Secretary may approve a lump-sum
4 payment in lieu of periodic allowances, where such payment
5 would constitute a more efficient and economic alternative.

6 “(3) (A) The Board shall notify a hospital of its find-
7 ings and recommendations.

8 “(B) A hospital dissatisfied with a recommendation
9 may obtain an informal or formal hearing at the discretion
10 of the Secretary, by filing (in the form and within a time
11 period established by the Secretary) a request for a hearing.

12 “(4) (A) Within thirty days after receiving a recom-
13 mendation from the Board respecting a transitional allow-
14 ance or, if later, within thirty days after a hearing the Sec-
15 retary shall make a final determination whether, and if so
16 in what amount and for what period of time, a transitional
17 allowance will be granted to a hospital. A final determination
18 of the Secretary shall not be subject to judicial review.

19 “(B) The Secretary shall notify a hospital and any other
20 appropriate parties of the determination.

21 “(C) Any transitional allowance shall take effect on a
22 date prescribed by the Secretary, but not earlier than the
23 date of completion of the qualified facility conversion. A tran-
24 sitional allowance shall be included as an allowable cost item

1 in determining the reasonable cost incurred by the hospital
2 in providing services for which payment is authorized under
3 this title": *Provided, however,* That the transitional allow-
4 ance shall not be considered in applying limits to costs
5 recognized as reasonable pursuant to the third sentence of
6 section 1861 (v) (1) and section 1861 (aa) of this Act
7 or in determining the amount to be paid to a provider
8 pursuant to section 1814 (b), section 1833 (a) (2), section
9 1910 (i) (3), and section 506 (f) (3) of this Act."

10 "(d) In determining the reasonable cost incurred by
11 a hospital with respect to which payment is authorized
12 under a State plan approved under title V or title XIX,
13 any transitional allowance shall be included as an allowable
14 cost item.

15 "(e) (1) The Secretary shall not, prior to January 1,
16 1981, establish a transitional allowance for more than a total
17 of fifty hospitals.

18 "(2) On or before January 1, 1980, the Secretary shall
19 report to the Congress evaluating the effectiveness of the
20 program established under this section including appropriate
21 recommendations."

22 (b) The amendments made by subsection (a) shall
23 apply only to services furnished by a hospital or skilled
24 nursing facility for fiscal years beginning on and after the

1 first day of the first calendar month following enactment
2 of this Act.

3 FEDERAL PARTICIPATION IN HOSPITAL CAPITAL

4 EXPENDITURES

5 SEC. 4. (a) Section 1122 (b) of the Social Security
6 Act is amended to read:

7 “(b) For purposes of this section, the State Health
8 Planning and Development Agency designated under sec-
9 tion 1521 of the Public Health Service Act shall serve as
10 the designated planning agency.”

11 (b) Section 1122 (c) is amended to read:

12 “(c) Expenses incurred by planning agencies shall be
13 payable from—

14 “(i) funds in the Federal Hospital Insurance Trust
15 Fund,

16 “(ii) funds in the Federal Supplementary Medical
17 Insurance Trust Fund, and

18 “(iii) funds appropriated to carry out the health
19 care provisions of the several titles of this Act,

20 in amounts as the Secretary finds results in a proper alloca-
21 tion. The Secretary shall transfer money between the funds
22 as may be appropriate to settle accounts between them. The
23 Secretary shall pay the planning agencies without requiring
24 contribution of funds by any State or political subdivision.”

25 (c) Section 1122 (d) is amended to read:

1 “(d) (1) Except as provided in paragraph (2), if the
2 Secretary determines that—

3 “(A) neither the Health Systems Agency nor the
4 designated planning agency had been notified of any
5 proposed capital expenditure at least sixty days prior to
6 obligation for the expenditure; or

7 “(B) (i) the designated planning agency had not
8 approved the proposed expenditure; and

9 “(i) the designated planning agency had granted
10 to the person proposing the capital expenditure an op-
11 portunity for a fair hearing with respect to the findings;
12 then, in determining Federal payments under titles V,
13 XVIII, and XIX for services furnished in the health care
14 facility for which the capital expenditure is made, the Secre-
15 tary shall not include any amount attributable to deprecia-
16 tion, interest on borrowed funds, a return on equity capital
17 (in the case of proprietary facilities), other expenses related
18 to the capital expenditure, or for direct operating costs, to
19 the extent that they can be directly associated with the
20 capital expenditure. In the case of a proposed capital ex-
21 penditure in a standard metropolitan statistical area which
22 encompasses more than one jurisdiction, that expenditure
23 shall require approval of the designated planning agency of
24 each jurisdiction who shall jointly review the proposal.

1 Where the designated planning agencies do not unanimously
2 agree, the proposed expenditure shall be deemed disapproved;
3 where the designated planning agencies do not act to approve
4 or disapprove the proposed expenditure within one hundred
5 and eighty days of submission of request for approval the
6 proposed expenditure shall be deemed approved; any deemed
7 approval or disapproval shall be subject to review and
8 reversal by the Secretary following a request submitted to
9 him within sixty days of the deemed approval or disapproval,
10 for a review and reconsideration based upon the record. With
11 respect to any organization which is reimbursed on a per
12 capita, fixed fee, or negotiated rate basis, in determining the
13 Federal payments to be made under titles V, XVIII, and
14 XIX, the Secretary shall exclude an amount reasonably
15 equivalent to the amount which would otherwise be excluded
16 under this subsection if payment were made on other than a
17 per capita, fixed fee, or negotiated rate basis.

18 “(2) If the Secretary, after submitting the matters in-
19 volved to the advisory council, determines that an exclusion
20 of expenses related to any capital expenditure would dis-
21 courage the operation or expansion of any health care facility
22 or health maintenance organization which has demonstrated
23 to his satisfaction proof of its capability to provide compre-
24 hensive health care services (including institutional services)
25 effectively and economically, or would be inconsistent with

1 effective organization and delivery of health services or ef-
 2 fective administration of title V, XVIII, or XIX, he shall
 3 not exclude the expenses pursuant to paragraph (1)."

4 (d) Section 1122(g) of the Social Security Act is
 5 amended to read:

6 " (g) For purposes of this section, a 'capital expenditure'
 7 is one which, under generally accepted accounting principles,
 8 is not properly chargeable as an expense of operation and
 9 maintenance and which (1) exceeds \$100,000, (2) changes
 10 the bed capacity of the facility, or (3) substantially changes
 11 the services of the facility, including conversion of existing
 12 beds to higher cost usage. The cost of studies, surveys, de-
 13 signs, plans, working drawings, specifications, and other ac-
 14 tivities essential to the acquisition, improvement, expansion,
 15 or replacement of the plant and equipment shall be included
 16 in determining whether the expenditure exceed \$100,000.

17 (e) Section 1861(z) of the Social Security Act is
 18 amended to read:

19 "Institutional Planning

20 " (z) An overall plan and budget of a hospital, skilled
 21 nursing facility, or home health agency shall—

22 " (1) provide for an annual operating budget which
 23 includes all anticipated income and expenses related to
 24 items which would, under generally accepted account-
 25 ing principles, be considered income and expense items

(except that nothing in this paragraph shall require that there be prepared, in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income) ;

“(2) provide for a capital expenditures plan for at least a five-year period (including the year to which the operating budget applies) which identifies in detail the sources of financing and the objectives of each anticipated expenditure in excess of \$100,000 related to the acquisition of land, improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment, and which would, under generally accepted accounting principles, be considered capital items. The capital expenditures plan shall be a matter of public record and available in readily accessible form and fashion;

“(3) provide for annual review and updating; and

“(4) be prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, administrative staff, and medical staff (if any) of the institution or agency.”

AGREEMENT BY PHYSICIANS TO ACCEPT ASSIGNMENTS

SEC. 10. (a) (1) Title XVIII of the Social Security Act is amended by adding the following section:

1 "AGREEMENTS OF PHYSICIANS TO ACCEPT ASSIGNMENT

2 "SEC. 1868. (a) For purposes of this section the term
3 'participating physician' means a doctor of medicine or oste-
4 opathy who has in effect an agreement by which he agrees
5 to accept an assignment of claim (as provided for in section
6 1842 (b) (3) (B) (ii)) for each physicians' service (other
7 than those excluded from coverage by section 1862) per-
8 formed by him in the United States for an individual enrolled
9 under this part. The assignment shall be in a form prescribed
10 by the Secretary. The agreement may be terminated by
11 either party upon thirty days' notice to the other, filed in a
12 manner prescribed by the Secretary.

13 "(b) To expedite processing of claims from participat-
14 ing physicians, the Secretary shall establish procedures and
15 develop appropriate forms under which—

16 "(1) each physician will submit his claims on one
17 of alternative simplified approved bases, including mul-
18 tiple listing of patients, and the Secretary shall act to
19 assure that these claims are processed expeditiously, and

20 "(2) The physician shall obtain from each patient
21 enrolled under this part (except in cases where the Sec-
22 retary finds it impractical for the patient to furnish it),
23 and shall make available at the Secretary's request, a
24 signed statement by which the patient: (i) agrees to
25 make an assignment with respect to all services fur-

1 nished by the physician; and (ii) authorizes the release
2 of any medical information needed to review claims
3 submitted by the physician.

4 “(c) (1) Participating physicians shall be paid ad-
5 ministrative cost-savings allowances (as specified below in
6 this subsection) in addition to the reasonable charges that
7 are payable.

8 “(2) The administrative cost-savings allowance shall
9 equal \$1 and shall be paid to the participating physician for
10 each claim he submits in accordance with the simplified bill-
11 ing procedure referred to in subparagraph (b) and these
12 payments shall be treated as an administrative expense to the
13 medical insurance program: *Provided, however, That:*

14 “(A) not more than \$1 shall be payable to a phy-
15 sician for claims for services furnished to any par-
16 ticular patient within any seven-day period; and

17 “(B) no administrative cost-savings allowance
18 shall be payable for services performed for a hospital
19 inpatient or outpatient unless:

20 “(i) the services are surgical services, anes-
21 thesia services, or services performed by a physician
22 who, as an attending or consulting physician who,
23 has personally examined the patient and whose
24 office or regular place of practice is located outside
25 a hospital, and

1 “(ii) the physician ordinarily bills directly (and
2 not through such hospital) for his services;

3 “(C) no administrative cost-savings allowance
4 shall be payable for services which consist solely of
5 laboratory or X-ray services which are for hospital
6 inpatients or outpatients or are performed outside the
7 office of the participating physician.”.

8 (b) The amendments made by paragraph (1) shall
9 become effective July 1, 1978.

10 **CRITERIA FOR DETERMINING REASONABLE CHARGE FOR**
11 **PHYSICIANS' SERVICES**

12 SEC. 11. (a) (1) So much of section 1842 (b) (3) of
13 the Social Security Act as follows the first sentence is
14 amended to read:

15 “(3A) (A) In determining the reasonable charge for
16 services for purposes of paragraph (3) (including any
17 hospital-associated physicians), there shall be taken into
18 consideration the customary charges for similar services
19 generally made by the physician or other person furnishing
20 such services, as well as the prevailing charges in the locality
21 for similar services.

22 “(B) (i) Except as otherwise provided in clause (iii),
23 no charge may be determined to be reasonable in the case of
24 bills submitted or requests for payment made under this part
25 after December 31, 1970, if it exceeds the higher of (I)

1 the prevailing charge recognized by the carrier and found
2 acceptable by the Secretary for similar services in the same
3 locality in administering this part on December 31, 1970, or
4 (II) the prevailing charge level that, on the basis of statis-
5 tical data and methodology acceptable to the Secretary,
6 would cover 75 per centum of the customary charges made
7 for similar services in the same locality during the last pre-
8 ceding calendar year elapsing prior to the start of the fiscal
9 year in which the bill is submitted or the request for pay-
10 ment is made.

11 “(ii) In the case of physician services the prevailing
12 charge level determined for purposes of clause (i) (II) for
13 any fiscal year beginning after June 30, 1973, may not
14 (except as otherwise provided in clause (iii)) exceed (in
15 the aggregate) the level determined under such clause for
16 the fiscal year ending June 30, 1973, except to the extent
17 that the Secretary finds, on the basis of appropriate econom-
18 ics index data, that such higher level is justified by economic
19 changes. Moreover, for any fiscal year beginning after June
20 30, 1978, no prevailing charge level for physicians' services
21 shall be increased to the extent that it would exceed by
22 more than one-third the statewide prevailing charge level
23 (as determined under subparagraph (E)) for that service.

24 “(iii) Notwithstanding the provisions of clauses (i) and
25 (ii) of this subparagraph, the prevailing charge level in the

1 case of a physician service in a particular locality determined
2 pursuant to such clauses for the fiscal year beginning July 1,
3 1975, shall, if lower than the prevailing charge level for the
4 fiscal year ending June 30, 1975, in the case of a similar
5 physician service in the same locality by reason of the appli-
6 cation of economic index data, be raised to such prevailing
7 charge level for the fiscal year ending June 30, 1975.

8 “(C) In the case of medical services, supplies, and
9 equipment (including equipment servicing) that, in the judg-
10 ment of the Secretary, do not generally vary significantly in
11 quality from one supplier to another, the charges incurred
12 after December 31, 1972, determined to be reasonable may
13 not exceed the lowest charge levels at which such services,
14 supplies, and equipment are widely and consistently available
15 in a locality except to the extent and under circumstances
16 specified by the Secretary.

17 “(D) The requirement in paragraph (3) (B) that a bill
18 be submitted or request for payment be made by the close of
19 the following calendar year shall not apply if (i) failure to
20 submit the bill or request the payment by the close of such
21 year is due to the error or misrepresentation of an officer,
22 employee, fiscal intermediary, carrier, or agent of the De-
23 partment of Health, Education, and Welfare performing
24 functions under this title and acting within the scope of his
25 or its authority, and (ii) the bill is submitted or the payment

1 is requested promptly after such error or misrepresentation
2 is eliminated or corrected.

3 “(E) The Secretary shall determine separate statewide
4 prevailing charge levels for each State that, on the basis of
5 statistical data and methodology acceptable to the Secretary,
6 would cover 50 percent of the customary charges made for
7 similar services in the State during the last preceding calen-
8 dar year elapsing prior to the start of the fiscal year in
9 which the bill is submitted or the request for payment is
10 made.

11 “(F) Notwithstanding any other provision of this para-
12 graph, any charge for any particular service or procedure
13 performed by a doctor of medicine or osteopathy shall be
14 regarded as a reasonable charge if—

15 “(i) the service or procedure is performed in an
16 area which the Secretary has designated as a physician
17 shortage area,

18 “the physician has a regular practice in the physi-
19 cian shortage area,

20 “(iii) the charge does not exceed the prevailing
21 charge level as determined under subparagraph (B),
22 and

23 “(iv) the charge does not exceed the physician’s
24 customary charge.”.

1 (2) The amendment made by paragraph (1) shall take
2 effect upon enactment.

3 HOSPITAL-ASSOCIATED PHYSICIANS

4 SEC. 12. (a) (1) Section 1861 (q) of the Social Se-
5 curity Act is amended by adding “(1)” immediately after
6 “(q)” and by adding, immediately before the period at the
7 end thereof, the following: “; except that the term does not
8 include any service that a physician may perform as an
9 educator, an executive, or a researcher; or any professional
10 patient care service unless the service (A) is personally
11 performed by or personally directed by a physician for the
12 benefit of the patient and (B) is of such nature that its
13 performance by a physician is customary and appropriate”.

14 (2) Section 1861 (q) is amended by adding the fol-
15 lowing paragraphs at the end:

16 “(2) In the case of anesthesiology services, a procedure
17 would be considered to be ‘personally performed’ in its en-
18 tirety by a physician where the physician performs the
19 following activities:

20 “(A) preanesthetic evaluation of the patient;

21 “(B) prescription of the anesthesia plan;

22 “(C) personal participation in the most demanding
23 procedures in this plan, including those of induction and
24 emergence and assuring that a qualified individual,
25 who need not be his employee, performs any of the

1 less demanding procedures which the physician does
2 not personally perform;

3 “(D) following the course of anesthesia adminis-
4 tration at frequent intervals;

5 “(E) remaining physically available for the im-
6 mediate diagnosis and treatment of emergencies; and

7 “(F) providing indicated postanesthesia care:

8 *Provided, however,* That during the performance of the activ-
9 ities described in subparagraphs (C), (D), and (E), the
10 physician is not responsible for the care of more than
11 one other patient. Where a physician performs the activities
12 described in subparagraphs (A), (B), (D), and (E) and
13 another individual performs the activities described in sub-
14 paragraph (C), the physician will be deemed to have
15 personally directed the services if he was responsible for no
16 more than four patients while performing the activities de-
17 scribed in subparagraphs (D) and (E) and the reasonable
18 charge for his personal direction shall not exceed one-half
19 the amount that would have been payable if he had person-
20 ally performed the procedure in its entirety.

21 “(3) Pathology services shall be considered ‘physicians’
22 services’ to patients only where the physician personally
23 performs acts or makes decisions with respect to a patient’s
24 diagnosis or treatment which require the exercise of medical
25 judgment. These include operating room and clinical con-

1 sultations, the required interpretation of the significance of
2 any material or data derived from a human being, the aspira-
3 tion or removal of marrow or other materials, and the ad-
4 ministration of test materials or isotopes. Such professional
5 services shall not include professional services such as: the
6 performance of autopsies; and services performed in carrying
7 out responsibilities for supervision, quality control, and for
8 various other aspects of a clinical laboratory's operations
9 that are customarily performed by nonphysician personnel.

10 (3) Section 1861 (b) of such Act is amended—

11 (A) by striking out “or” at the end of paragraph

12 (6),

13 (B) by striking out the period at the end of para-
14 graph (7) and inserting “; or”, and

15 (C) by adding at the end the following paragraph:

16 “(8) a physician, if the services provided are not
17 physicians' services (within the meaning of subsection
18 (q)).”.

19 (b) (1) Section 1861 (s) of the Social Security Act
20 is amended by adding at the end: “The term ‘medical and
21 other health services’ shall not include services described in
22 paragraphs (2) (A) and (3) if furnished to inpatients of a
23 provider of services unless the Secretary finds that, because
24 of the size of the hospital and the part-time nature of the
25 services or for some other reason acceptable to him, it would

1 be less efficient to have the services furnished by the hospital
2 (or by others under arrangement with them made by the
3 hospital) than to have them furnished by another party.”.

4 (2) Section 1842 (b) (3A) of such Act, as added by
5 section 20 of this Act, is amended by adding:

6 “(G) The charge for a physician’s or other per-
7 son’s services and items which are related to the income
8 or receipts of a hospital or hospital subdivision shall not
9 be considered in determining his customary charge to
10 the extent that the charge exceeds an amount equal to
11 the salary which would reasonably have been paid for
12 the service (together with any additional costs that
13 would have been incurred by the hospital) to the physi-
14 cian performing it if it had been performed in an employ-
15 ment relationship with the hospital plus the cost of other
16 expenses (including a reasonable allowance for travel-
17 time and other reasonable types of expense related to
18 any differences in acceptable methods of organization
19 for the provision of services) incurred by the physician,
20 as the Secretary may determine to be appropriate.”.

21 (c) Section 1861 (v) of the Social Security Act is
22 amended by adding:

23 “(8) (A) Where physicians’ services are furnished
24 under an arrangement (including an arrangement under
25 which the physician performing the services is compensated

1 on a basis related to the amount of the income or receipts of
2 the hospital or any department or other subdivision) with
3 a hospital or medical school, the amount included in any
4 payment to the hospital under this title as the reasonable
5 cost of the services (as furnished under the arrangement)
6 shall not exceed an amount equal to the salary which would
7 reasonably have been paid for the services (together with
8 any additional costs that would have been incurred by the
9 hospital) to the physician performing them if they had
10 been performed in an employment relationship with the
11 hospital (rather than under such arrangement) plus the
12 cost of other expenses (including a reasonable allowance for
13 traveltime and other reasonable types of expense related to
14 any differences in acceptable methods of organization for the
15 provision of the services) incurred by the physician, as the
16 Secretary may determine to be appropriate.”.

17 (d) (1) Section 1833 (a) (1) (B) of the Social Secu-
18 rity Act is amended by inserting “(except as provided in
19 subsection (h))” immediately after “amounts paid shall”.

20 (2) Section 1833 (b) (2) of such Act is amended by
21 inserting “(except as otherwise provided in subsection
22 (h))” immediately after “amount paid shall”.

23 (3) Section 1833 of such Act is amended by adding:
24 “(h) The provisions of subsection (a) (1) (B) and
25 clause (2) of the first sentence of subsection (b) shall not

1 apply to any physician unless he has entered into an
 2 agreement with the Secretary under which he agrees to be
 3 compensated for all such services on the basis of an assign-
 4 ment the terms of which are described in section 1842 (b)
 5 (3) (B) (ii).”.

6 (e) The amendments made by this section shall, except
 7 those made by subsection (d), apply to services furnished
 8 in accounting periods of the hospital which begin after the
 9 month following the month of enactment of this Act. The
 10 amendment made by subsection (d) shall be effective July
 11 1, 1978.

12 PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF
 13 MEDICARE

14 SEC. 13. (a) Section 1861 (s) (2) of the Social Security
 15 Act is amended—

16 (1) by striking out “and” at the end of clause
 17 (C),

18 (2) by inserting “and” at the end of clause (D),
 19 and

20 (3) by adding after clause (D) the following new
 21 clause:

22 “(E) antigens (subject to reasonable quantity lim-
 23 itations determined by the Secretary) prepared by an
 24 allergist for a particular patient, including antigens he
 25 prepares which are forwarded to another qualified per-

1 son for administration to the patient by or under the
2 supervision of another physician;”.

3 (b) Subsection (a) shall apply to items furnished after
4 the month of enactment of this Act.

5 PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS’
6 FEES ON ACCOUNT OF SERVICES FURNISHED TO A
7 DECEASED INDIVIDUAL

8 SEC. 14. (a) Section 1870 (f) of the Social Security
9 Act is amended, in the matter following clause (2) thereof,
10 by—

11 (1) inserting “(A)” immediately after “, and only
12 if”, and

13 (2) by inserting immediately before the period the
14 following: “, or (B) the spouse or other legally desig-
15 nated representative of such individual requests (in
16 such form and manner as the Secretary shall by regula-
17 tions prescribe) that payment for such services without
18 regard to clause (A)”.

19 (b) Subsection (a) shall apply to payments made after
20 the month of enactment.

21 USE OF APPROVED RELATIVE VALUE SCHEDULE

22 SEC. 15. (a) To provide common language describing
23 the various kinds and levels of medical services which may
24 be reimbursed under titles V, XVIII, and XIX, of the Social
25 Security Act, the Secretary of Health, Education, and Wel-

1 fare shall establish a system of procedural terminology, in-
2 cluding definitions of the terms. The system shall be de-
3 veloped by the Health Care Financing Administration with
4 the advice of other large health care purchasers, representa-
5 tives of professional groups and other interested parties.
6 In developing the system, the Health Care Financing
7 Administration shall consider among other things, the
8 experience of third parties in using existing terminology
9 systems in terms of: implications for administrative and
10 program costs; simplicity and lack of ambiguity; and the
11 degree of acceptance and use.

12 (b) Upon development of a proposed system of proce-
13 dural terminology and its approval by the Secretary of
14 Health, Education, and Welfare, it shall be published in
15 the Federal Register. Interested parties shall have not less
16 than six months in which to comment on the proposed sys-
17 tem and to recommend relative values to the Secretary for
18 the procedures and services designated by the terms. Com-
19 ments and proposals shall be supported by information and
20 documentation specified by the Secretary.

21 (c) The good faith preparation of a relative value sched-
22 ule or its submission to the Secretary by an association of
23 health practitioners solely in response to a request of the
24 Secretary as authorized under this section shall not in itself
25 be considered a violation of any consent decree by which

1 an association has waived its right to make recommendations
2 concerning fees: *Provided*, That the proposed relative value
3 schedule shall not be disclosed to anyone other than those
4 persons actually preparing it or their counsel until it is made
5 public by the Secretary.

6 (d) The Health Care Financing Administration shall
7 review materials submitted under this section and shall
8 recommend that the Secretary adopt a specific terminology
9 system and its relative values for use by carriers in calculat-
10 ing reasonable charges under title XVIII of the Social
11 Security Act, but only after:

12 (1) Interested parties have been given an oppor-
13 tunity to comment and any comments have been
14 considered;

15 (2) Statistical analyses have been conducted assess-
16 ing the economic impact of the relative values on the
17 physicians in various specialties, geographic areas and
18 types of practice, and on the potential liability of the
19 program established by part B of title XVIII of the
20 Social Security Act;

21 (3) It has been determined that the proposed ter-
22 minology and related definitions are unambiguous, prac-
23 tical, and easy to evaluate in actual clinical situations
24 and that the unit values assigned generally reflect the

1 relative time and effort required to perform various
2 procedures and services.

3 (4) That the use of the proposed system will en-
4 hance the administration of the Federal health care
5 financing programs.

6 (e) A system of terminology, definitions, and their
7 relative values, as approved by the Secretary, shall be pe-
8 riodically reviewed by him and may be modified. An ap-
9 proved system (as amended by any modification of the
10 Secretary) may subsequently be used by any organization
11 or person for purposes other than those of this Act. Nothing
12 in this section shall be considered to bar the Secretary from
13 adopting a uniform system of procedural terminology in
14 situations where a relative value schedule has not been
15 approved.

16 HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

17 SEC. 20. (a) Section 1861 of the Social Security Act
18 is amended by adding after subsection (aa) (as added by
19 section 10 (b) of this Act) the following:

20 "Hospital Providers of Extended Care Services

21 "(bb) (1) (A) Any hospital (other than a hospital
22 which has in effect a waiver of the requirement imposed by
23 subsection (e) (5)) which has an agreement under section
24 1866 may (subject to paragraph (2)) enter into an agree-
25 ment with the Secretary under which its inpatient hospital

1 facilities may be used for the furnishing of services of the
2 type which, if furnished by a skilled nursing facility, would
3 constitute post-hospital extended care services.

4 “(B) (i) Notwithstanding any other provision of this
5 title, payment to any hospital for services furnished under
6 an agreement entered into under this subsection shall be
7 based upon the reasonable cost of the services as determined
8 under this subparagraph.

9 “(ii) The reasonable cost of the services will consist of
10 the reasonable cost of routine services and ancillary services.
11 The reasonable cost of routine services furnished during any
12 calendar year by a hospital under an agreement under this
13 subsection shall equal the product of the number of patient-
14 days during the year for which the services were furnished
15 and the average reasonable cost per patient-day. The aver-
16 age reasonable cost per patient-day shall be established as
17 the average rate per patient-day paid for routine services
18 during the previous calendar year under title XIX to skilled
19 nursing facilities located in the State in which the hospital is
20 located and which have agreements entered into under sec-
21 tion 1902a (28). The reasonable cost of ancillary services
22 shall be determined in the same manner as the reasonable
23 cost of ancillary services provided for inpatient hospital
24 services.

1 “(2) (A) The Secretary shall not enter into an agree-
2 ment under this subsection with any hospital unless—

3 “(i) for a period specified by the Secretary (not
4 less than twelve months) which immediately precedes
5 the date the agreement is entered into, the hospital has
6 had an average daily occupancy rate of less than 60
7 percent,

8 “(ii) the hospital is located in a rural area and has
9 less than 50 beds, and

10 “(iii) the hospital has been granted a certificate
11 of need for the provision of long-term care services
12 from the agency of the State (which has been desig-
13 nated as the State health planning and development
14 agency under an agreement pursuant to section 1521
15 of the Public Health Service Act) in which the hospital
16 is located.

17 “(3) An agreement with a hospital entered into under
18 this section shall, except as otherwise provided under reg-
19 ulations of the Secretary, be of the same duration and
20 subject to termination on the same conditions as are agree-
21 ments with skilled nursing facilities under section 1866,
22 unless the hospital fails to satisfy the requirements defined
23 in paragraph (2) (A) of this subsection and shall, where not
24 inconsistent with any provision of this subsection, impose
25 the same duties, responsibilities, conditions, and limitations,

1 as those imposed under such agreements entered into under
2 section 1866; except that no such agreement with any hos-
3 pital shall be in effect for any period during which the hos-
4 pital does not have in effect an agreement under section
5 1866, or where there is in effect for the hospital a waiver of
6 the requirement imposed by subsection (e) (5). A hospital
7 whose agreement has been terminated shall not be eligible
8 to undertake a new agreement until a two-year period has
9 elapsed from the termination date.

10 “(4) Any agreement with a hospital under this sub-
11 section shall provide that payment for services will be made
12 only for services for which payment would be made as post-
13 hospital extended care services, if those services had been
14 furnished by a skilled nursing facility under an agreement
15 entered into under section 1866; and any individual who is
16 furnished services, for which payment may be made under an
17 agreement, shall, for purposes of this title (other than this
18 subsection), be deemed to have received post-hospital ex-
19 tended care services in like manner and to the same extent
20 as if the services furnished to him had been post-hospital
21 extended care services furnished by a skilled nursing facility
22 under an agreement under section 1866.

23 “(5) During a period for which a hospital has in effect
24 an agreement under this subsection, in order to allocate rou-
25 tine costs between hospital and long-term care services for

1 purposes of determining payment for inpatient hospital serv-
2 ices (including the application of reimbursement limits speci-
3 fied in section 1861 (aa)), the total reimbursement received
4 for routine services from all classes of long-term care patients,
5 including title XVIII, title XIX, and private pay patients,
6 shall be subtracted from the hospital's total routine costs
7 before calculations are made to determine title XVIII reim-
8 bursement for routine hospital services.

9 “(6) During any period during which an agreement is
10 in effect with a hospital under this subsection, the hospital
11 shall, for services furnished by it under the agreement, be
12 considered to satisfy the requirements, otherwise required, of
13 a skilled nursing facility for purposes of the following pro-
14 visions: sections 1814 (a) (2) (C), 1814 (a) (6), 1814 (a)
15 (7), 1814 (h), 1861 (a) (2), 1861 (i), 1861 (j) (except
16 1861 (j) (12)), and 1861 (n) ; and the Secretary shall
17 specify any other provisions of this Act where the hospital
18 may be considered as a skilled nursing facility.

19 “(7) (c) Within three years after enactment, the Secre-
20 tary shall provide a report to the Congress containing an
21 evaluation of the program established under this subsection
22 concerning:

23 “(1) The extent and effect of the agreements on
24 availability and effective and economical provision of
25 long-term care services,

1 “(2) whether the program should be continued,
2 and

3 “(3) whether eligibility should be extended to
4 other hospitals, regardless of bed size or geographic lo-
5 cation, where there is a shortage of long-term care
6 beds.”.

7 (b) Title XIX of such Act is amended by adding at
8 the end thereof the following new section :

9 “HOSPITAL PROVIDERS OF SKILLED NURSING AND INTER-
10 MEDIATE CARE SERVICES

11 “SEC. 1911. (a) Notwithstanding any other provision
12 of this title, payment may be made, in accordance with
13 this section, under an approved State plan for skilled nurs-
14 ing services and intermediate care services furnished by a
15 hospital which has in effect an agreement under section
16 1861 (bb).

17 “(b) (1) Payment to any such hospital, for any skilled
18 nursing or intermediate care services furnished, shall be at a
19 rate equal to the average rate per patient-pay paid for routine
20 services during the previous calendar year under this title
21 to skilled nursing and intermediate care facilities located in
22 the State in which the hospital is located. The reasonable
23 cost of ancillary services shall be determined in the same
24 manner as the reasonable cost of ancillary services provided
25 for inpatient hospital services.

1 “(2) With respect to any period for which a hospital
2 has an agreement under section 1861 (bb), in order to allo-
3 cate routine costs between hospital and long-term care serv-
4 ices, the total reimbursement for routine services received
5 from all classes of long-term care patients, including title
6 XVIII, title XIX, and private pay patients, shall be sub-
7 tracted from the hospital total routine costs before calcula-
8 tions are made to determine title XIX reimbursement for
9 routine hospital services.”.

10 (c) The amendments made by this section shall be-
11 come effective on the date on which final regulations, promul-
12 gated by the Secretary to implement the amendments, are
13 issued; and those regulations shall be issued not later than
14 the first day of the sixth calendar month following the month
15 in which this Act is enacted.

16 REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED
17 NURSING AND INTERMEDIATE CARE FACILITIES

18 SEC. 21. Section 1902 (a) (13) (E) of the Social Se-
19 curity Act is amended by inserting “(and which may, at the
20 option of the State, include a reasonable profit for the facil-
21 ity in the form of: (a) fixed per diem amounts or, (b)
22 incentive payments related to efficient performance, or (c)
23 a rate of return on net equity)” immediately after “cost
24 related basis”.

1 MEDICAID CERTIFICATION AND APPROVAL OF SKILLED
2 NURSING AND INTERMEDIATE CARE FACILITIES

3 SEC. 22. (a) Section 1910 of the Social Security Act is
4 amended to read:

5 "CERTIFICATION AND APPROVAL OF SKILLED NURSING AND
6 INTERMEDIATE CARE FACILITIES

7 "SEC. 1910. (a) The Secretary shall make an agree-
8 ment with any State which is willing and able to do so
9 whereby the State health agency or other appropriate State
10 or local agencies (whichever are utilized by the Secretary
11 pursuant to section 1864 (a)) will be utilized to recommend
12 to him whether an institution in the State qualifies as a
13 skilled nursing facility (for purposes of section 1902 (a)
14 (28)) or an intermediate care facility (for purposes of sec-
15 tion 1905 (c)).

16 "(b) The Secretary shall advise the State agency ad-
17 ministering the medical assistance plan of his approval or
18 disapproval of any institution certified to him as a qualified
19 skilled nursing or intermediate care facility for purposes of
20 section 1902 (a) (28) and specify for each institution the
21 period (not to exceed twelve months) for which approval is
22 granted, except that the Secretary may extend that term
23 for up to two months, where the health and safety of patients
24 will not be jeopardized, if he finds that an extension is
25 necessary to prevent irreparable harm to the facility or

1 hardship to the facility's patients or if he finds it impracti-
2 cable within the twelve-month period to determine whether
3 the facility is complying with the provisions of this title and
4 applicable regulations. The State agency may upon approval
5 of the Secretary enter into an agreement with any skilled
6 nursing or intermediate care facility for the specified approval
7 period.

8 “(c) The Secretary may cancel approval of any skilled
9 nursing or intermediate care facility at any time if he finds
10 that a facility fails to meet the requirements contained in
11 section 1902 (a) (28) or section 1905 (c), or if he finds
12 grounds for termination of his agreement with the facility
13 pursuant to section 1866 (b). In that event the Secretary
14 shall notify the State agency and the skilled nursing or inter-
15 mediate care facility that approval of eligibility of the facility
16 to participate in the programs established by this title and
17 title XVIII shall be terminated at a time specified by the
18 Secretary. The approval of eligibility of any such facility to
19 participate in the programs may not be reinstated unless the
20 Secretary finds that the reason for termination has been re-
21 moved and there is reasonable assurance that it will not
22 recur.

23 “(d) Effective July 1, 1978, no payment may be made
24 to any State under this title for skilled nursing or intermedi-
25 ate care facility services furnished by any facility—

1 “(1) which does not have in effect an agreement
2 with the State agency pursuant to subsection (b), or

3 “(2) whose approval of eligibility to participate in
4 the programs established by this title or title XVIII
5 has been terminated by the Secretary and has not been
6 reinstated, except that payment may be made for up to
7 thirty days for skilled nursing or intermediate care fa-
8 cility services furnished to any eligible individual who
9 was admitted to the facility prior to the effective date of
10 the termination.”.

11 “(e) Any skilled nursing facility or intermediate care
12 facility which is dissatisfied with any determination by the
13 Secretary that it no longer qualifies as a skilled nursing
14 facility or intermediate care facility for purposes of this
15 title shall be entitled to a hearing by the Secretary to the
16 same extent as is provided in section 205 (b) and to judicial
17 review of the Secretary’s final decision after such hearing as
18 is provided in section 205 (g) . Any agreement between such
19 facility and the State agency shall remain in effect until the
20 period for filing a request for a hearing has expired or, if a
21 request has been filed, until a decision has been made by the
22 Secretary: *Provided, however,* That the agreement shall
23 not be extended if the Secretary makes a written determina-
24 tion, specifying the reasons therefor, that the continuation
25 of provider status constitutes an immediate and serious

1 threat to the health and safety of patients, and if the Secre-
2 tary certifies that the facility has been notified of its defi-
3 ciencies and has failed to correct them.”.

4 (b) Section 1869 (c) of the Social Security Act is
5 amended by adding at the end the following sentence: “If
6 the Secretary’s determination terminates a provider with an
7 existing agreement pursuant to section 1866 (b) (2), or if
8 that determination consists of a refusal to renew an existing
9 provider agreement, the provider’s agreement shall remain in
10 effect until the period for filing a request for a hearing has
11 expired or, if a request has been filed, until a final decision
12 has been made by the Secretary: *Provided, however, That*
13 the agreement shall not be extended if the Secretary makes a
14 written determination, specifying the reasons therefor, that
15 the continuation of provider status constitutes an immediate
16 and serious threat to the health and safety of patients and if
17 the Secretary certifies that the provider has been notified
18 of such deficiencies and has failed to correct them.”.

19 (c) The amendments made by this section shall be-
20 come effective on the date on which final regulations, promul-
21 gated by the Secretary to implement the amendments, are
22 issued; and those regulations shall be issued not later than

1 the first day of the sixth calendar month following the month
2 in which this Act is enacted.

3 VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED
4 NURSING OR INTERMEDIATE CARE FACILITIES

5 SEC. 23. Section 1903 of the Social Security Act is
6 amended by adding:

7 “(1) In the administration of this title, the fact that an
8 individual who is an inpatient of a skilled nursing or inter-
9 mediate care facility leaves to make visits outside the facility
10 shall not conclusively indicate that he does not need services
11 which the facility is designed to provide; however, the fre-
12 quency and length of visits away shall be considered, to-
13 gether with other evidence, in determining whether the in-
14 dividual is in need of the facility’s services.”.

15 ESTABLISHMENT OF HEALTH CARE FINANCING

16 ADMINISTRATION

17 SEC. 30. (a) Section 702 of the Social Security Act is
18 amended—

19 (1) by inserting “(a)” immediately after “SEC.
20 702.”, and

21 (2) by adding at the end the following subsection:

22 “(b) The Secretary shall establish, within the De-
23 partment of Health, Education, and Welfare, a separate
24 organization to be known as the Health Care Financing
25 Administration (which shall include the functions and per-

1 sonnel of administrative entities known as of January 1, 1977
2 as the 'Bureau of Health Insurance', the 'Medical Services
3 Administration', the 'Bureau of Quality Assurance' (includ-
4 ing the National Professional Standards Review Council),
5 and the 'Office of Long-Term Care' and related research
6 and statistical units (including the Division of Health In-
7 surance Studies of the Social Security Administration)
8 which shall be under the direction of the Assistant Secre-
9 tary for Health Care Financing, who shall report directly
10 to the Secretary and who shall have policy and adminis-
11 trative responsibility (including policy and administrative
12 responsibility with respect to health care standards and certi-
13 fication requirements as they apply to practitioners and in-
14 stitutions) for the programs established by titles XVIII
15 and XIX, part B of title XI, for the renal disease program
16 established by section 226 and any other health care financ-
17 ing programs as may be established under this Act. The
18 Assistant Secretary may not have any other duties or func-
19 tions assigned to him which would prevent him from carrying
20 out the duties required under the preceding sentence on a full-
21 time basis.

22 (b) (1) There shall be in the Department of Health,
23 Education, and Welfare an Assistant Secretary for Health
24 Care Financing, who shall be appointed by the President,
25 by and with the advice and consent of the Senate.

1 (2) Section 5315 of title 5, United States Code, is
 2 amended in paragraph (17) by striking out "(5)" and
 3 inserting in lieu thereof "(6)".

4 STATE MEDICAID ADMINISTRATION

5 SEC. 31. (a) Section 1902 (a) is amended by adding at
 6 the end the following:

7 “(37) provide—

8 “(A) for making eligibility determinations on
 9 the basis of applications for coverage, within forty-
 10 five days of the date of application for all individ-
 11 uals: (i) receiving aid or assistance (or who ex-
 12 cept for income and resources would be eligible for
 13 aid or assistance) under a plan of the State ap-
 14 proved under title IV, part A, (ii) receiving aid or
 15 assistance (or who except for income and resources
 16 would be eligible for assistance) under any plan
 17 of the State approved under title I, X, or XVI
 18 (for the aged and the blind), or (iii) with respect
 19 to whom supplemental security income benefits are
 20 being paid (or who would except for income and
 21 resources be eligible to have paid with respect to
 22 them supplemental security income benefits) under
 23 title XVI on the basis of age or blindness; and

24 “(B) for making eligibility determina-

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1 tions based upon applications for coverage, within
2 sixty days of application for all individuals:

3 (i) receiving aid or assistance (or who except for
4 income and resources would be eligible for aid or
5 assistance) on the basis of disability under any plan
6 of the State approved under title XIV or XVI, or
7 (ii) for whom supplemental security income bene-
8 fits are being paid (or who would except for income
9 and resources be eligible to have paid to them
10 supplemental security income benefits) under title
11 XVI based upon disability;

12 “(C) for making redeterminations of eligi-
13 bility for persons specified in subparagraphs
14 (A) and (B): (i) when required based upon
15 information the agency has previously obtained on
16 anticipated changes in the individual's situation, (ii)
17 within thirty days after receiving information on
18 changes in an individual's circumstances which may
19 affect his eligibility, and (iii) periodically but not
20 less often than every six months for persons speci-
21 fied in subparagraph (A) (i), and not less often
22 than annually for persons specified in subparagraph
23 (A) (ii) and (A) (iii);

24 “(38) establish procedures to assure accurate
25 determinations of eligibility and provide that the error

1 rate for eligibility determinations made on or after
2 October 1, 1977, shall not exceed the rate specified in
3 section 1911 (b) ; and

4 “(39) establish payment procedures to assure that
5 (A) 95 percent of claims for which no further written
6 information or substantiation is required to make pay-
7 ment, be paid within thirty days of receipt of the claim
8 from a provider, and that 99 percent of such claims be
9 paid within ninety days, and (B) both prepayment
10 and postpayment claims review procedures are per-
11 formed, including—

12 “(i) review, on a reasonable sample or more
13 extensive basis, to determine the accuracy of data
14 submitted and processed;

15 “(ii) review to determine that the provider is a
16 participating provider;

17 “(iii) review to determine whether the service
18 is covered under the State’s plan;

19 “(iv) review to determine whether the recip-
20 ient is eligible;

21 “(v) review of care and services provided
22 where such review has not been assumed by an
23 organization designated by the Secretary under
24 part B of title XI of this Act;

1 “(vi) review to determine that payments made
2 do not exceed those allowable;

3 “(vii) review to determine and recover any
4 third party liability;

5 “(viii) review which reasonably safeguards
6 against duplicate billing.”.

7 (b) Section 1902 (a) (6) is amended by adding the
8 following at the end: “the reports are to be accurate and
9 filed within sixty days following the close of the reporting
10 period for monthly and quarterly reports, and within one
11 hundred and five days following the close of reporting
12 periods for yearly reports;”.

13 (c) Amend section 1903 by adding at the end the
14 following subsection:

15 “(n) (1) Effective with each calendar quarter beginning
16 October 1, 1978 the amount paid to each State under para-
17 graphs (a) (2), (a) (3), and (a) (6) shall be reduced or
18 terminated unless the State demonstrates to the Secretary
19 that—

20 “(A) 95 percent of eligibility determinations are
21 made within the time periods specified under section
22 1902 (a) (37) (A) and (B), except that in determin-
23 ing whether a State has met the requirements of this
24 paragraph there shall not be included eligibility deter-
25 minations for persons whose eligibility is determined

1 under State plans approved under title I, X, XIV, XVI,
2 or part A of title IV, or by the Secretary under sec-
3 tion 1634;

4 “(B) the State’s eligibility determination error rate
5 does not exceed the rate specified in section 1911 (b),
6 except that in determining whether a State has met the
7 requirements of this paragraph there shall not be
8 included error rates for those persons whose eligi-
9 bility is determined under a State plan approved under
10 titles I, X, XIV, XVI, or part A of title IV or by
11 the Secretary under section 1634;

12 “(C) the State is processing claims for payment
13 within the time period specified in section 1902 (a)
14 (39) (A) and applying prepayment and postpayment
15 claims review procedures specified in section 1902 (a)
16 (39) (B) ; and

17 “(D) the State is making timely and complete
18 reports to the Secretary on the operation of its medi-
19 cal assistance program within the time period includ-
20 ing the information specified in section 1902 (a) (6) .

21 “(2) The Secretary shall conduct an onsite survey in
22 each State, at least annually, of State performance in each
23 category under paragraph (1) . The methodology and pro-
24 cedures (which may involve onsite evaluation) employed,
25 including procedures for any necessary followup of any de-

1 deficiencies, must be formally approved by the Comptroller
2 General of the United States;

3 “(3) Any State which fails to meet one or more of the
4 requirements specified in subparagraph (A), (B), (C)
5 or (D) of paragraph (1) shall be formally notified within
6 thirty days of the survey of the deficiencies. The State shall
7 be given an appropriate period of time, not to exceed six
8 months, to correct the deficiencies;

9 “(4) Any State which fails to correct deficiencies within
10 the time period specified under paragraph (3) as determined
11 by the Secretary shall be notified and subject to a reduction
12 in Federal matching as specified in paragraph (5) beginning
13 on the first day of the first calendar quarter following the
14 date on which the Secretary specified the deficiencies must be
15 corrected under paragraph (3);

16 “(5) (A) Where the Secretary finds that a State failed
17 to meet the requirements of one of the subparagraphs (A),
18 (B), (C), or (D) of paragraph (1) and has not made cor-
19 rections required under paragraph (4), Federal matching
20 shall be reduced to 50 percent of what the State would other-
21 wise receive under subsections (a) (2), (a) (3), and (a)
22 (6).

23 “(B) Where the Secretary determines that a State fail-
24 ed to meet requirements of two or more of subparagraphs
25 (A), (B), (C), or (D) of paragraph (1) and that it has

1 not made the corrections as determined under paragraph
2 (4), its Federal matching shall be terminated under sub-
3 sections (a) (2), (a) (3), and (a) (6).

4 “(6) (A) Any State which had had Federal matching
5 reduced or terminated under paragraph (5) shall continue to
6 have the matching reduced or terminated until the Secretary
7 determines that the deficiencies have been corrected.

8 “(B) A State determined to have corrected all cate-
9 gories specified as deficient shall be entitled to the matching
10 rate specified in subsections (a) (2), (a) (3), and (a) (6)
11 beginning on the first day of the calendar quarter in which
12 the corrections were made.

13 “(C) In a State where matching has been terminated
14 under subsections (a) (2), (a) (3), and (a) (6) as pro-
15 vided under subparagraph (5) (B) and where the Secretary
16 determines that deficiencies continue in only one of the four
17 specified categories, that State shall, beginning on the first
18 day of the calendar quarter in which the correction was
19 made, be entitled to the reduced matching rate specified in
20 subparagraph (5) (A).

21 “(7) Where a State is determined by the Secretary
22 based upon an onsite evaluation to substantially exceed the
23 requirements of at least two of subparagraphs (A), (B),
24 (C), or (D) of paragraph (1) and meets the requirements
25 of the remaining subparagraphs, that State shall be notified

1 and entitled to a Federal matching rate under subsection
2 (a) (6) of 75 percent and that amount shall apply in each
3 calendar quarter for which the Secretary finds the State con-
4 tinues to meet the requirements of this paragraph;

5 “(8) The Secretary shall provide or arrange for the
6 reasonable provision of technical assistance by experienced
7 and qualified Federal, State, or local governmental person-
8 nel to any State which requests assistance in meeting the
9 requirements of paragraph (1).

10 “(9) If the Secretary notifies a State of deficiencies, or
11 a reduction, termination, or increase in Federal matching,
12 simultaneous notification shall also be made to the Governor
13 of the State, and the respective chairmen of the legislative
14 and appropriation committees of that State’s legislature
15 having jurisdiction over the medical assistance program
16 authorized under this title.”

17 (d) Title XIX of the Social Security Act is amended by
18 adding at the end the following new sections:

19 “QUALITY CONTROL

20 “SEC. 1911. The Secretary shall—

21 “(a) determine the eligibility error rates, including
22 cases incorrectly approved and cases incorrectly denied,
23 for each State for the six-month period commencing
24 with the first calendar quarter beginning six months
25 following enactment of this title. The Secretary shall

1 exclude those cases for which the most recent determina-
2 tion or redetermination of eligibility was correctly
3 made, but where eligibility status subsequently changed,
4 if the State meets the time requirements specified in
5 section 1902 (a) (37) ;

6 “(b) establish a State classification system, with
7 States classified according to: (1) whether the State
8 provides medical assistance for persons specified in sec-
9 tion 1902 (a) (10) (C) ; and (2) population, with those
10 States with greater populations in one grouping and
11 those States with lesser populations in another ;

12 “(c) establish an error rate defined as the rate
13 which equals the 75th percentile of the rates reported
14 by the States under paragraph (a) for each class of
15 States under (b) .

16 “REPORT BY THE SECRETARY

17 “SEC. 1912. The Secretary shall prepare a biannual
18 report (beginning with fiscal year 1978) on the character-
19 istics of the State programs of medical assistance financed
20 under this title, including, at least (1) a description of the
21 scope and duration of benefits available in each State, (2) a
22 description of eligibility criteria for all groups eligible for
23 medical assistance, (3) specification of the reimbursement
24 methodology for payments under the State program for the
25 major types of services, and (4) a listing of all fiscal agents,

1 insurers and health maintenance organizations contracted
2 with for administration of the program. Such report shall be
3 submitted to the Committee on Finance of the Senate and
4 the Committee on Interstate and Foreign Commerce of the
5 House of Representatives no later than six months following
6 the close of the fiscal year.”

7 REGULATIONS OF THE SECRETARY

8 SEC. 32. (a) (1) Section 1102 of the Social Security
9 Act is amended—

10 (A) by inserting “(a)” immediately after “SEC.
11 1102.”, and

12 (B) by adding at the end the following subsection:

13 “(b) Whenever the Secretary, in compliance with
14 requirements imposed by law, has published in the Federal
15 Register general notice of any proposed rule or regulation
16 to be promulgated by him, that notice shall indicate whether
17 prompt promulgation is urgent. Where the notice indicates
18 that prompt promulgation is urgent, the rule or regulation
19 shall become effective within sixty days after publication of
20 the notice; in any other case, the rule or regulation shall
21 become effective without regard to the provisions of this
22 subsection in the manner prescribed by applicable provisions
23 of law.”.

24 (2) Amendments made by paragraph (1) shall be
25 effective for proposed rules published in the Federal Register

1 on and after the first day of the first calendar month which
2 begins more than thirty days after the date of enactment of
3 this Act.

4 (b) Except as otherwise specified in this Act or
5 in a provision of law which is enacted or amended by
6 this Act, any regulation of the Secretary of Health, Educa-
7 tion, and Welfare (hereinafter in this section referred to as
8 the "Secretary"), which is necessary or appropriate to im-
9 plement any provision of this Act or any other provision of
10 law which is enacted or modified by this Act, shall, subject
11 to paragraph (2), be promulgated so as to become effective
12 not later than the first day of the thirteenth month following
13 the month in which this Act is enacted.

14 REPEAL OF SECTION 1867

15 SEC. 33. Section 1867 of the Social Security Act is
16 hereby repealed.

17 PROCEDURES FOR DETERMINING REASONABLE COST AND
18 REASONABLE CHARGE

19 SEC. 40. (a) (1) In determining the amount of any
20 payment under title XVIII, under a program established
21 under title V, or under a State plan approved under title
22 XIX, when the payment is based upon the reasonable cost
23 or reasonable charge, no element comprising any part of
24 the cost or charge shall be considered to be reasonable if, and
25 to the extent that, that element is—

1 (A) a commission, finder's fee, or for a similar
2 arrangement, or

3 (B) an amount payable for any facility (or part
4 or activity thereof) under any rental or lease arrange-
5 ment

6 which is, directly or indirectly, determined, wholly or in
7 part as a percentage, fraction, or portion of the charge or
8 cost attributed to any health service (other than the ele-
9 ment) or any health service including, but not limited to,
10 the element.

11 AMBULANCE SERVICE

12 SEC. 41. (a) Section 1861 (s) (7) of the Social Security
13 Act is amended by inserting:

14 “(Including ambulance service to the nearest hos-
15 pital which is: (a) adequately equipped and (b) has
16 medical personnel qualified to deal with, and available
17 for the treatment of, the individual's illness, injury, or
18 condition)” immediately after “ambulance service”.

19 (b) The amendment made by subsection (a) shall
20 apply to services furnished on and after the first day of the
21 first calendar month which begins after the date of enact-
22 ment of this Act.

23 GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

24 SEC. 42. (a) Section 511 of the Social Security Act is
25 amended—

1 (1) by inserting "(a)" immediately after "SEC.
2 511.", and

3 (2) by adding at the end of the section:

4 "(b) (1) From the sums available under paragraph
5 (2), the Secretary is authorized to make grants to public
6 or nonprofit private regional pediatric respiratory centers,
7 which are a part of (or are affiliated with) an institution of
8 higher learning, to assist them in carrying out a program for
9 the training and instruction (through demonstrations and
10 otherwise) of health care personnel in the prevention, diag-
11 nosis and treatment of respiratory diseases in children and
12 young adults, and in providing (through such program)
13 needed health care services to children and young adults
14 suffering from such diseases.

15 "(2) For the purpose of making grants under this sub-
16 section, there is authorized to be appropriated, for the fiscal
17 year ending September 30, 1978, and each of the next four
18 succeeding fiscal years, such sums (not in excess of \$5,-
19 000,000 for any fiscal year) as may be necessary. Sums
20 authorized to be appropriated for any fiscal year under this
21 subsection for making grants for the purposes referred to in
22 paragraph (1) shall be in addition to any sums authorized
23 to be appropriated for such fiscal year for similar purposes
24 under other provisions of this title."

25 (b) Section 502 (2) of such Act is amended by insert-
26 ing "(a)" immediately after "511".

1 WAIVER OF HUMAN EXPERIMENTATION PROVISION

2 FOR MEDICARE AND MEDICAID

3 SEC. 43. Any requirements of title II of Public Law
4 93-348 otherwise held applicable are hereby waived with
5 respect to programs established under titles XVIII and XIX
6 of the Social Security Act.

7 DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

8 SEC. 44. Section 1106 of the Social Security Act is
9 amended by adding:

10 “(f) The Secretary shall not make available, nor shall
11 the State title XIX agency be required to make available
12 to the public information relating to the amounts that have
13 been paid to individual doctors of medicine or osteopathy
14 by or on behalf of beneficiaries of the health programs estab-
15 lished by titles XVIII or XIX, as the case may be, except
16 as may be necessary to carry out the purposes of those titles
17 or as may be specifically required by the provisions of other
18 Federal law.”.

19 RESOURCES OF MEDICAID APPLICANT TO INCLUDE CERTAIN
20 PROPERTY PREVIOUSLY DISPOSED OF TO APPLICANT'S
21 RELATIVE FOR LESS THAN MARKET VALUE

22 SEC. 45. Section 1904 of the Social Security Act is
23 amended by adding the following sentence: “The Secretary
24 shall not find that a State has failed to comply with the re-
25 quirements of this title solely because it denies medical as-

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- 1 That no payments will be made under this subpara-
- 2 graph, in the case of a hospital, for October 1980 or any
- 3 month thereafter.”.

95TH CONGRESS
1ST SESSION

H. R. 8423

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 13, 1977

Read twice and referred to the Committee on Finance

AN ACT

To amend titles II and XVIII of the Social Security Act to make improvements in the end stage renal disease program presently authorized under section 226 of that Act, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 That (a) title II of the Social Security Act is amended by
4 inserting immediately after section 226 the following new
5 section:

6 “SPECIAL PROVISIONS RELATING TO COVERAGE UNDER
7 MEDICARE PROGRAM FOR END STAGE RENAL DISEASE

8 “SEC. 226A. (a) Notwithstanding any provision to
 II

1 the contrary in section 226 or title XVIII, every individual
2 who—

3 “(1) (A) is fully or currently insured (as such
4 terms are defined in section 214 of this Act) or would
5 be fully or currently insured if his service as an em-
6 ployee (as defined in the Railroad Retirement Act of
7 1974) after December 31, 1936, were included in the
8 term ‘employment’ as defined in this Act, or (B) is
9 entitled to monthly insurance benefits under title II
10 of this Act or an annuity under the Railroad Retirement
11 Act of 1974, or (C) is the spouse or dependent
12 child (as defined in regulations) of an individual who
13 is fully or currently insured or would be fully or cur-
14 rently insured if his service as an employee (as defined
15 in the Railroad Retirement Act of 1974) after Decem-
16 ber 31, 1936, were included in the term ‘employment’
17 as defined in this Act, or (D) is the spouse or depend-
18 ent child (as defined in regulations) of an individual
19 entitled to monthly insurance benefits under title II
20 of this Act or an annuity under the Railroad Retirement
21 Act of 1974; and

22 “(2) is medically determined to have end stage
23 renal disease, and requires renal dialysis or renal trans-
24 plantation for such disease,
25 shall be deemed to be disabled (and to have satisfied the

3

1 requirements of section 226 (b) (2)) for purposes of en-
2 titlement to benefits under parts A and B of title XVIII,
3 subject to the deductible, premium, and coinsurance provi-
4 sions of that title.

5 “(b) Subject to subsection (c), entitlement of an in-
6 dividual to benefits under parts A and B of title XVIII by
7 reasons of this section on the basis of end stage renal
8 disease—

9 “(1) shall begin with—

10 “(A) the third month after the month in which
11 a regular course of renal dialysis is initiated, or

12 “(B) the first month in which such individual
13 is admitted as an inpatient to an institution which is
14 a hospital meeting the requirements of section 1861
15 (e) (and such additional requirements as the Secre-
16 tary may prescribe under section 1881 (b) for such
17 institutions) in preparation for or anticipation of
18 kidney transplant surgery, but only if such surgery
19 occurs in that month or in either of the next two
20 months,

21 whichever first occurs; and

22 “(2) shall end, in the case of an individual who
23 receives a kidney transplant, with the thirty-sixth month
24 after the month in which such individual receives such
25 transplant or, in the case of an individual who has not

1 received a kidney transplant and no longer requires
2 a regular course of dialysis, with the twelfth month
3 after the month in which such course of dialysis is
4 terminated.

5 “(c) Notwithstanding the provisions of subsection
6 (b) —

7 “(1) in the case of any individual who participates
8 in a self-care dialysis training program prior to the third
9 month after the month in which such individual initiates
10 a regular course of renal dialysis in a renal disease facil-
11 ity or provider of services meeting the requirements of
12 section 1881 (b), entitlement to benefits shall begin with
13 the month in which such regular course of renal dialysis
14 is initiated; and

15 “(2) in any case where a kidney transplant fails
16 (whether during or after the thirty-six-month period
17 specified in subsection (b) (2)) and as a result the
18 individual who received such transplant initiates or
19 resumes a regular course of renal dialysis, such individ-
20 ual shall be entitled to benefits under parts A and B of
21 title XVIII beginning with the month in which such
22 failure occurs.”.

23 (b) Section 226 of such Act is amended—

24 (1) by striking out subsections (e), (f), and (g),
25 and

5

1 (2) by redesignating subsections (h) and (i) as
2 subsections (e) and (f), respectively.

3 SEC. 2. Part C of title XVIII of the Social Security Act
4 is amended by adding at the end thereof the following new
5 section:

6 "MEDICARE COVERAGE FOR END STAGE RENAL DISEASE
7 PATIENTS

8 "SEC. 1881. (a) The benefits provided by parts A and
9 B of this title shall include benefits for individuals who have
10 been determined to have end-stage renal disease as provided
11 in section 226A, and benefits for kidney donors as provided
12 in subsection (d) of this section. Notwithstanding any
13 other provision of this title, the type, duration, and scope of
14 the benefit provided by parts A and B with respect to indi-
15 viduals who have been determined to have end-stage renal
16 disease and who are entitled to such benefits without regard
17 to section 226A shall in no case be less than the type, dura-
18 tion, and scope of the benefits so provided for individuals
19 entitled to such benefits solely by reason of that section.

“ (b) (1) Payments under this title with respect to serv-
ices, in addition to services for which payment would other-
wise be made under this title, furnished to individuals who
have been determined to have end-stage renal disease shall
include (A) payments on behalf of such individuals to pro-
viders of services and renal dialysis facilities which meet such

6

1 requirements as the Secretary shall by regulation prescribe
2 for institutional dialysis services, transplantation services,
3 self-dialysis services in a self-care dialysis unit maintained by
4 the provider or facility, and home dialysis support serv-
5 ices which are furnished by the provider or facility, and
6 (B) payments to or on behalf of such individuals for home
7 dialysis supplies and equipment. The requirements prescribed
8 by the Secretary under subparagraph (A) shall include
9 requirements for a minimum utilization rate for covered pro-
10 cedures and for self-dialysis training programs.

11 “(2) (A) With respect to payments for dialysis serv-
12 ices furnished by providers of services and renal dialysis fa-
13 cilities to individuals determined to have end-stage renal dis-
14 ease for which payments may be made under part B of this
15 title, such payments (unless otherwise provided in this sec-
16 tion) shall be equal to 80 percent of the amounts determined
17 in accordance with subparagraph (B) ; and with respect to
18 payments for services for which payments may be made
19 under part A of this title, the amounts of such payments
20 (which amounts shall not exceed, in respect to costs in pro-
21 curing organs attributable to payments made to an organ
22 procurement agency or histocompatibility laboratory, the
23 costs incurred by that agency or laboratory) shall be deter-
24 mined in accordance with section 1861 (v). Payments shall
25 be made to a renal dialysis facility only if it agrees to accept

1 such payments as payment in full for covered services, ex-
2 cept for payment by the individual of 20 percent of the costs
3 for such services (as determined in accordance with sub-
4 paragraph (B)) and the deductible amount imposed by sec-
5 tion 1833 (b) .

6 “(B) The Secretary shall prescribe in regulations any
7 methods and procedures to (i) determine the costs incurred
8 by providers of services and renal dialysis facilities in fur-
9 nishing covered services to individuals determined to have
10 end-stage renal disease, and (ii) determine, on a cost-related
11 basis or other economical and equitable basis (including any
12 basis authorized under section 1861 (v)) , the amounts of
13 payments to be made for part B services furnished by such
14 providers and facilities to such individuals. Such regulations
15 shall provide for the implementation of appropriate incen-
16 tives for encouraging more efficient and effective delivery of
17 services (consistent with quality care), and shall include,
18 to the extent determined feasible by the Secretary, prospec-
19 tively set rates, a system for classifying comparable providers
20 and facilities, and target rates with arrangements for shar-
21 ing such reductions in costs as may be attributable to more
22 efficient and effective delivery of services.

23 “(C) Such regulations, in the case of services furnished
24 by proprietary providers and facilities may include, if the
25 Secretary finds it feasible and appropriate, provision for

1 recognition of a reasonable rate of return on equity capital,
2 providing such rate of return does not exceed the rate of
3 return stipulated in section 1861 (v) (1) (B).

4 “(D) For purposes of section 1878, a renal dialysis
5 facility shall be treated as a provider of services.

6 “(3) With respect to payments for services furnished
7 by physicians to individuals determined to have end-stage
8 renal disease, the Secretary may make payment for such
9 services on an individual service basis (and may, in such
10 case, make payment on the basis of the customary and pre-
11 vailing charges of other physicians for comparable services),
12 or on the basis of an aggregate of services provided over a
13 period of time (as defined in regulations) ; and, with respect
14 to aggregate physician services expected to be provided over
15 a period of time, the Secretary may provide for payment on
16 a comprehensive fee basis.

17 “(4) Pursuant to agreements with approved providers
18 of services and renal dialysis facilities, the Secretary may
19 make payment to such providers and facilities for the cost of
20 home dialysis supplies and equipment and home dialysis
21 support services furnished to patients dialyzing at home
22 whose home dialysis care is under the direct supervision of
23 such provider or facility, on the basis of a target reimburse-
24 ment rate (as defined in paragraph (6)).

1 “(5) An agreement under paragraph (4) shall re-
2 quire that the provider or facility will—

3 “(A) assume full responsibility for directly ob-
4 taining or arranging for the provision of—

5 “(i) such medically necessary dialysis equip-
6 ment as is prescribed by the attending physician;

7 “(ii) dialysis equipment maintenance and re-
8 pair services;

9 “(iii) the purchase and delivery of all neces-
10 sary medical supplies; and

11 “(iv) where necessary, the services of trained
12 home dialysis aides;

13 “(B) perform all such administrative functions and
14 maintain such information and records as the Secretary
15 may require to verify the transactions and arrangements
16 described in subparagraph (A) ;

17 “(C) submit such cost reports, data, and informa-
18 tion as the Secretary may require with respect to the
19 costs incurred for equipment, supplies, and services
20 furnished to the facility’s home dialysis patient popu-
21 lation; and

22 “(D) provide for full access for the Secretary to
23 all such records, data, and information as he may require
24 to perform his functions under this section.

1 “(6) The Secretary shall establish, for each calendar
2 year, commencing with January 1, 1978, a target reimburse-
3 ment rate for home dialysis which shall be adjusted for
4 regional variations in the cost of providing home dialysis.
5 In establishing such a rate, the Secretary shall include—

6 “(A) the Secretary’s estimate of the cost of pro-
7 viding medically necessary home dialysis supplies and
8 equipment;

9 “(B) an allowance, in an amount determined by the
10 Secretary, to cover the cost of providing personnel to
11 aid in home dialysis; and

12 “(C) an allowance, in an amount determined by
13 the Secretary, to cover administrative costs and to pro-
14 vide an incentive for the efficient delivery of home
15 dialysis;

16 but in no event shall such target rate exceed 70 percent of
17 the national average payment, adjusted for regional varia-
18 tions, for a maintenance dialysis service furnished in ap-
19 proved providers and facilities during the preceding fiscal
20 year. Any such target rate so established shall be utilized,
21 without renegotiation of the rate, throughout the calendar
22 year for which it is established. During the last quarter of
23 each calendar year, the Secretary shall establish a home
24 dialysis target reimbursement rate for the next calendar year
25 based on the most recent data available to the Secretary

1 at the time. In establishing any rate under this paragraph,
2 the Secretary may utilize a competitive-bid procedure, a pre-
3 negotiated rate procedure, or any other procedure which the
4 Secretary determines is appropriate and feasible in order to
5 carry out this paragraph in an effective and efficient
6 manner.

7 “(7) For purposes of this title, the term ‘home dialysis
8 supplies and equipment’ means medically necessary supplies
9 and equipment (including supportive equipment) required
10 by an individual suffering from end-stage renal disease in
11 connection with renal dialysis carried out in his home (as
12 defined in regulations), including obtaining, installing, and
13 maintaining such equipment.

14 “(8) For purposes of this title, the term ‘self-care home
15 dialysis support services’, to the extent permitted in regula-
16 tion, means—

17 “(A) periodic monitoring of the patient’s home
18 adaptation, including visits by qualified provider or
19 facility personnel (as defined in regulations), so long as
20 this is done in accordance with a plan prepared and
21 periodically reviewed by a professional team (as defined
22 in regulations) including the individual’s physician;

23 “(B) installation and maintenance of dialysis
24 equipment;

1 “(C) testing and appropriate treatment of the
2 water; and

3 “(D) such additional supportive services as the
4 Secretary finds appropriate and desirable.

5 “(9) For purposes of this title, the term ‘self-care di-
6 alysis unit’ means a renal disease facility or a distinct part
7 of such facility or of a provider of services, which has been
8 approved by the Secretary to make self-dialysis services, as
9 defined by the Secretary in regulations, available to indi-
10 viduals who have been trained for self-dialysis. A self-care
11 dialysis unit must, at a minimum, furnish the services, equip-
12 ment and supplies needed for self-care dialysis, have patient-
13 staff ratios which are appropriate to self-dialysis (allowing
14 for such appropriate lesser degree of ongoing medical super-
15 vision and assistance of ancillary personnel than is required
16 for full care maintenance dialysis), and meet such other re-
17 quirements as the Secretary may prescribe with respect to
18 the quality and cost-effectiveness of services.

19 “(c) (1) For the purpose of assuring effective and effi-
20 cient administration of the benefits provided under this
21 section, the Secretary shall establish, in accordance with
22 such criteria as he finds appropriate, renal disease net-
23 work areas, such network organizations (including a medi-
24 cal review board for each network area) as he finds neces-
25 sary to accomplish such purpose, and a national end stage

1 renal disease medical information system. The Secretary
2 may by regulations provide for such coordination of net-
3 work planning and quality assurance activities and such
4 exchange of data and information among agencies with re-
5 sponsibilities for health planning and quality assurance ac-
6 tivities under Federal law as is consistent with the eco-
7 nomical and efficient administration of this section and with
8 the responsibilities established for network organizations and
9 medical review boards under this section.

10 “(2) The network organization and the medical review
11 board of each network shall be responsible, in addition to
12 such other duties and functions as may be prescribed by the
13 Secretary, for—

14 “(A) encouraging, to the maximum extent possi-
15 ble, consistent with sound medical practice, the use of
16 those treatment settings most compatible with the suc-
17 cessful rehabilitation of the patient;

18 “(B) developing, on the basis of normative data
19 derived from the renal disease medical information
20 system and criteria and standards developed within the
21 network, network goals relating to the quality and
22 appropriateness of patient care, including goals with
23 respect to the appropriate proportion of network patients
24 dialyzing in self-care settings and undergoing or prepar-
25 ing for transplantation;

1 “(C) evaluating the procedures by which facilities
2 and providers in the network assess the appropriateness
3 of patients for proposed treatment modalities;

4 “(D) identifying facilities and providers that are
5 not cooperating toward meeting network goals; request-
6 ing explanations and plans for correction from such
7 facilities and providers; and approving or recommending
8 plans for such correction; and

9 “(E) submitting an annual report to the Secretary
10 on July 1 of each year which shall include a full state-
11 ment of the network’s goals, data on the network’s
12 performance in meeting its goals (including data on the
13 comparative performance of facilities and providers with
14 respect to the identification and placement of suitable
15 candidates in self-care settings and transplantation),
16 identification of those facilities that have consistently
17 failed to cooperate with network goals, and recommen-
18 dations with respect to the need for additional or alter-
19 native services or facilities in the network in order to
20 meet the network goals, including self-dialysis training,
21 transplantation, and organ procurement facilities.

22 “(3) The Secretary shall evaluate the adequacy of each
23 network’s goals, in relation to the national objective estab-
24 lished in accordance with paragraph (4), and the perform-
25 ance of the network in meeting these goals, and may rec-

1 commend such modifications in the goals and the methods
2 for achieving them as he deems appropriate. Where the Sec-
3 retary determines, on the basis of the data contained in the
4 network's annual report and such other relevant data as may
5 be available to him, that a facility or provider has consistently
6 failed to cooperate with network plans and goals, he may
7 terminate or withhold certification of such facility or provider
8 (for purposes of payment for services furnished to individuals
9 with end stage renal disease) until he determines that such
10 provider or facility is making reasonable and appropriate
11 efforts to cooperate with the network's plans and goals.

12 “(4) The national objective with respect to the appro-
13 priate proportion of patients in self-dialysis settings and pre-
14 paring for or undertaking transplantation is that a majority
15 of new patients being accepted for end-stage renal disease
16 treatment should be in self-dialysis settings or be transplanted.
17 The Secretary shall, after consultation with appropriate pro-
18 fessional and network organizations, and after taking into
19 account available evidence relating to developments in re-
20 search, treatment methods and technology, periodically eval-
21 uate and, when he determines necessary, recommend revision
22 of the national objective to the Congress.

23 “(5) The Secretary shall, in determining whether to
24 certify additional facilities or expansion of existing facilities
25 within a network, take into account the network's goals and

1 performance as reflected in the network's annual report, and
2 assure himself that where a network has a low self-dialysis
3 treatment percentage such percentage can be satisfactorily
4 justified before certifying additional beds or facilities.

5 “(6) The Secretary shall, on the basis of the annual
6 network reports, determine the extent to which self-dialysis
7 training within each network is adequate to the patient
8 size and referral patterns of the area. Where the Secretary
9 finds that self-training programs in any network are of in-
10 sufficient capacity or are not distributed throughout the net-
11 work in a manner which assures that self-dialysis training
12 is adequate to meet the needs of individuals with renal
13 disease, he shall place in effect a program under which self-
14 dialysis training is provided in renal disease facilities or pro-
15 viders which shall be designated by him for this purpose.
16 Where a provider or facility so designated is subsequently
17 found by the Secretary to have failed to provide the required
18 self-dialysis training, he may terminate or withhold certifica-
19 tion of such provider or facility (for purposes of payment for
20 services furnished to individuals with end stage renal dis-
21 ease) until such provider or facility is in compliance with the
22 requirements concerning the provision of self-dialysis
23 training.

24 “(d) Notwithstanding any provision to the contrary
25 in section 226, any individual who donates a kidney for

1 transplant surgery shall be entitled to benefits under parts
2 A and B of this title with respect to such donation. Reim-
3 bursement for the reasonable expenses incurred by such an
4 individual with respect to a kidney donation shall be made
5 (without regard to the deductible, premium, and coinsur-
6 ance provisions of this title), in such manner as may be
7 prescribed by the Secretary in regulations, for all prepara-
8 tory, operation, and postoperation recovery costs associated
9 with such donation, including but not limited to the costs
10 for which payment could be made if he were an eligible
11 individual for purposes of parts A and B of this title with-
12 out regard to this subsection. Postoperation recovery costs
13 shall be limited to the actual period of recovery.

14 “(e) (1) Notwithstanding any other provision of this
15 title, the Secretary may, pursuant to agreements with
16 approved providers of services and renal dialysis facilities,
17 reimburse such providers and facilities (without regard to
18 the deductible and coinsurance provisions of this title) for
19 the reasonable cost of the purchase, installation, maintenance
20 and reconditioning for subsequent use of artificial kidney
21 and automated dialysis peritoneal machines (including sup-
22 portive equipment) which are to be used exclusively by
23 entitled individuals dialyzing at home.

24 “(2) An agreement under this subsection shall require
25 that the provider or facility will—

1 “(A) make the equipment available for use only
2 by entitled individuals dialyzing at home;

3 “(B) recondition the equipment, as needed, for
4 reuse by such individuals throughout the useful life of
5 the equipment, including modification of the equipment
6 consistent with advances in research and technology;

7 “(C) provide for full access for the Secretary to
8 all records and information relating to the purchase,
9 maintenance, and use of the equipment; and

10 “(D) submit such reports, data, and information
11 as the Secretary may require with respect to the cost,
12 management, and use of the equipment.

13 “(3) For purposes of this section, the term ‘sup-
14 portive equipment’ includes blood pumps, heparin pumps,
15 bubble detectors, other alarm systems, and such other items
16 as the Secretary may determine are medically necessary.

17 “(f) (1) The Secretary shall initiate and carry out, at
18 selected locations in the United States, pilot projects under
19 which financial assistance in the purchase of new or used
20 durable medical equipment for renal dialysis is provided to
21 individuals suffering from end stage renal disease at the
22 time home dialysis is begun, with provision for a trial
23 period to assure successful adaptation to home dialysis
24 before the actual purchase of such equipment.

25 “(2) The Secretary shall conduct experiments to

1 evaluate methods for reducing the costs of the end stage
2 renal disease program. Such experiments shall include
3 (without being limited to) reimbursement for nurses and
4 dialysis technicians to assist with home dialysis, reimburse-
5 ment to family members assisting with home dialysis, and
6 (to the extent medically sound) incentives to home dial-
7 ysis patients to clean and reuse their dialysis filters.

8 “(3) The Secretary shall conduct experiments to evalu-
9 ate methods of dietary control for reducing the costs of the
10 end stage renal disease program, including (without being
11 limited to) the use of protein-controlled products to delay
12 the necessity for, or reduce the frequency of, dialysis in the
13 treatment of end stage renal disease.

14 “(4) The Secretary shall conduct a comprehensive
15 study of methods for increasing public participation in kidney
16 donation and other organ donation programs.

17 “(5) The Secretary shall conduct a full and complete
18 study of the reimbursement of physicians for services fur-
19 nished to patients with end stage renal disease under this
20 title, giving particular attention to the range of payments to
21 physicians for such services, the average amounts of such
22 payments, and the number of hours devoted to furnishing
23 such services to patients at home, in renal disease facilities,
24 in hospitals, and elsewhere.

25 “(6) The Secretary shall conduct a study of the num-

1 ber of patients with end stage renal disease who are not
2 eligible for benefits with respect to such disease under this
3 title (by reason of this section or otherwise), and of the
4 economic impact of such noneligibility of such individuals.
5 Such study shall include consideration of mechanisms where-
6 by governmental and other health plans might be instituted
7 or modified to permit the purchase of actuarially sound
8 coverage for the costs of end stage renal disease.

9 “(7) The Secretary shall submit to the Congress no
10 later than October 1, 1978, a full report on the experiments
11 conducted under paragraphs (1), (2), and (3) and the
12 studies under paragraphs (4), (5), and (6). Such report
13 shall include any recommendations for legislative changes
14 which the Secretary finds necessary or desirable as a result
15 of such experiments and studies.

16 “(g) The Secretary shall submit to the Congress on
17 October 1, 1978, and on October 1 of each year thereafter,
18 a report on the end stage renal disease program, including
19 but not limited to—

20 “(1) the number of patients, nationally and by
21 renal disease network, on dialysis (self-dialysis or other-
22 wise) at home and in facilities;

23 “(2) the number of new patients entering dialysis
24 at home and in facilities during the year;

1 “(3) the number of facilities providing dialysis and
2 the utilization rates of those facilities;

3 “(4) the number of kidney transplants, by source
4 of donor organ;

5 “(5) the number of patients awaiting organs for
6 transplant;

7 “(6) the number of transplant failures;

8 “(7) the range of costs of kidney acquisitions, by
9 type of facility and by region;

10 “(8) the number of facilities providing transplants
11 and the number of transplants performed per facility;

12 “(9) patient mortality and morbidity rates;

13 “(10) the average annual cost of hospitalization for
14 ancillary problems in dialysis and transplant patients,
15 and drug costs for transplant patients;

16 “(11) medicare payment rates for dialysis, trans-
17 plant procedures, and physician services, along with
18 any changes in such rates during the year and the
19 reasons for those changes;

20 “(12) the results of cost-saving experiments;

21 “(13) the results of basic kidney disease research
22 conducted by the Federal Government, private institu-
23 tions, and foreign governments;

1 “(14) information on the activities of medical re-
2 view boards and other network organizations; and

3 “(15) estimated program costs over the next five
4 years.”.

5 SEC. 3. (a) Section 226 (a) of the Social Security Act
6 is amended—

7 (1) by striking out “specified in subparagraph
8 (B)” and inserting in lieu thereof “specified in para-
9 graph (1)”; and

10 (2) by striking out “specified in subparagraphs
11 (A) and (B)” and inserting in lieu thereof “specified
12 in paragraphs (1) and (2)”.

13 (b) Paragraphs (2) and (3) of section 226 (e) of
14 such Act (as redesignated by subsection (b) (2) of the
15 first section of this Act) are each amended by striking out
16 “subsection b” and inserting in lieu thereof “subsection
17 (b)”.

18 SEC. 4. (a) Section 1833 (a) (1) of the Social Security
19 Act is amended—

20 (1) by striking out “and” at the end of clause (C),
21 and

22 (2) by adding the following after “and” in clause
23 (D) :

24 “(E) with respect to services furnished to individ-
25 uals who have been determined to have end stage renal

1 disease, the amounts paid shall be determined pursuant
2 to section 1881, and”.

3 (b) Section 1833 (a) (2) of such Act is amended by
4 inserting “(unless otherwise specified in section 1881)”
5 after “other services”.

6 (c) Section 1861 (s) (2) of such Act is amended—

7 (1) by striking out “and” at the end of clause (C),

8 (2) by inserting “and” at the end of clause (D),

9 and

10 (3) by adding the following new clause after sub-
11 clause (D) :

12 “(E) home dialysis supplies and equipment, self-
13 care home dialysis support services, and self-dialysis
14 services;”.

15 (d) The first sentence of section 1866 (a) (2) (A) of
16 such Act is amended by inserting the following before the
17 period: “(but in the case of items and services furnished
18 to individuals with end-stage renal disease, an amount equal
19 to 20 percent of the estimated amounts for such items and
20 services calculated on the cost-related basis established by
21 the Secretary)”.

22 SEC. 5. The third sentence of section 1817 (b) of the
23 Social Security Act, and the third sentence of section 1841
24 (b) of such Act, are each amended by striking out “Com-
25 missioner of Social Security” and inserting in lieu thereof

1 "Administrator of the Health Care Financing Administra-
2 tion.

3 SEC. 6. The amendments made by this Act shall be-
4 come effective with respect to services, supplies, and equip-
5 ment furnished after the third calendar month which begins
6 after the date of the enactment of this Act, except that those
7 amendments providing for the implementation of an incen-
8 tive reimbursement system shall become effective with re-
9 spect to a facility's or provider's first accounting period which
10 begins on or after October 1, 1978.

Passed the House of Representatives September 12,
1977.

Attest: EDMUND L. HENSHAW, JR.,
Clerk.

Senator TALMADGE. This morning we will hear testimony on various proposals designed to constrain the rapid and continuing explosion of hospital expenditures. In 1970, total U.S. payments for hospital care was \$26 billion. This year, those expenditures are estimated at \$65 billion, a 150-percent increase in 7 years. But this enormous cost surge is not limited to hospitals.

In 1970, total expenditures for doctors' services was \$13.4 billion. In 1977, those costs are estimated at \$30.5 billion. We have a great deal to be proud of in our hospital system in this country. There is a real sense, at the same time, that much could be done to improve the current situation.

President Carter has proposed across-the-board controls on hospital revenues. Four congressional committees have been actively working on health care cost control legislation.

Unfortunately, while the health care cost problems are urgent and major, we have, at best, only partial answers. Maybe as a result of a hearing such as this, we legislators can make rough justice a little smoother. Maybe we can moderate those whose zealous efforts would result in throwing the baby out with the bath.

Since the inception of the medicare and medicaid programs, the Committee on Finance has been concerned about the cost of these programs. Our amendments have, over the years, had the effect of moderating hospital and medical costs somewhat. But, as the figures I cited indicate, obviously the effect of what we have done has been limited.

Throughout all of our work, and up to and including the present, we have been sensitive to the need to try to distinguish between those hospitals which are efficient and those which are less than efficient in the delivery of care.

Our objective, at least my objective, is the same as that of the President: Moderate the rise in health care costs. We are not so far apart.

The principal difference, I believe, is that some of us are perhaps more sensitive to the need to sort out the efficient from the inefficient. Some of us recognize shortcomings in our data and in our present ability to identify and define inefficiency.

Some of us are concerned about the possibility of doing irreparable harm to the very hospitals which have been among the most efficient. Some of us, in order to help prevent irreparable damage to our hospitals, would prefer, at least initially, to allow too many expectations, rather than too few.

The distinguished Secretary of Health, Education, and Welfare, Mr. Califano, who is with us today, has referred to obese hospitals. I do not think he would argue with me when I say while there are many obese hospitals there are also many lean hospitals. My concern is that in order to trim the fat from these obese hospitals, we do not prescribe for all hospitals, fat and lean, a 1,200 calorie diet.

I have been working along with the committee staff for quite a few months in an effort to develop reasonably equitable hospital cost containment approaches; approaches which, in addition, do not recognize excessive costs and would also have an incentive payment to reward efficiency.

During our hearings in July on S. 1470, the Medicare and Medicaid Administrative and Reimbursement Reform Act, I directed the staff

to see whether the approach I had included for dealing with hospital costs under medicare and medicaid might be expanded to cover all payors and most hospital inpatient revenues.

Additionally, I asked them to see whether the timetable under our bill could be speeded up. Last week, I received staff suggestions, and I understand that many of the witnesses at these hearings will comment on these suggestions.

After reviewing the testimony of these hearings, we will then decide whether, and to what extent, those suggestions might be feasible legislatively.

Before we hear from Secretary Califano, I should also like to point out that these hearings will include testimony on H.R. 8423, the House-passed bill designed to improve the operation of the medicare program for people who have suffered kidney failure. Most of the witnesses on that subject will be heard on Friday, October 21.

Senator Dole, do you have any statement?

Senator DOLE. Yes, Mr. Chairman, a few brief remarks. Again I want to commend the chairman for pursuing what all of us consider to be a very vital problem. Certainly, we agree with the Secretary, who has stated eloquently time and time again the need to do something. Hopefully we can arrive at something that can satisfy some of the concerns that we all have.

I am certain that many may have noted in this week's U.S. News and World Report a rather extensive article on rising costs and the fact—I would quote from that article—that “Studies show that three out of every four doctors consider medical costs their biggest problems.” It is not confined to those of us on this side, or to those in the administration, it is reaching out into the profession itself. We are talking about a fiscal 1978 expenditure of approximately \$47.5 billion. This amount certainly indicates the need for some cost control.

There is no question that health care costs have grown. It has almost grown to the brink of absolute loss of control, and of course, because of that, we are here again today.

I would only quote one other comment in U.S. News which said:

It is none other than the doctors themselves who are at the core of the cost crisis. Although physicians collect only 20 percent of all of the money spent on health, according to HEW, they generate 70 percent of the total costs, when bills paid for drugs, surgery, hospitalization, and other medical procedures ordered by doctors are counted.

I am not certain that I agree with that conclusion or assumption, but certainly physicians have contributed and must look carefully at themselves and help us to find some way out of this minefield that we are in.

We all agree that we must find some way to control the ever-rising costs. I am very pleased to have an opportunity to hear the witnesses again.

Thank you, Mr. Chairman.

Senator TALMADGE. Senator Dole, if it is agreeable with you, we will limit our questions to 10 minutes on the first round. If we require more time, then we will take more than one round.

Mr. Secretary, we are honored, indeed, to have you back before our committee. You may proceed in any manner you see fit.

**STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY,
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, AND ROBERT A. DERZON, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION**

Secretary CALIFANO. Mr. Chairman, it is a great pleasure to be here this morning. I appreciate the chance to come here again before this committee and I recognize the tremendous work that you have done, and the work that Senator Dole has done, in the area of cost containment in our health care services over many years.

If I may, Mr. Chairman, I would like to read just a portion of my statement, and, Mr. Chairman, I appreciate the opportunity to appear before the Subcommittee on Health to discuss the revised version of S. 1470, your Medicare-Medicaid Administrative and Reimbursement Reform Act, the President's hospital cost containment bill, and the hospital cost containment bill reported out by the Human Resources Committee.

The suggestions and discussions of S. 1470 resulting from the work you directed your staff to do clearly demonstrates to us the intention of this subcommittee to continue its outstanding role in identifying serious problems and devising needed reforms in the Nation's health care system.

Although there is no higher national priority in health than controlling the precipitous and intolerable escalation of hospital costs, this subcommittee has shown by its extraordinary work that initiatives in the hospital cost area are only one aspect of the overall need for reform in the delivery and financing of health services.

For example, this subcommittee's longstanding effort to secure passage of much needed reforms to curb fraud and abuse in the medicare and medicaid programs is about to reach fruition with the Presidential signing of legislation that does you great credit.

I would like to note publicly, as I have to you privately, I think your work on that legislation is extraordinary, one of the finest pieces of legislation in this area.

Senator TALMADGE. On behalf of the subcommittee, and full Finance Committee, I thank you, sir.

Secretary CALIFANO. I commend the staff, also. I commit, fully, as Secretary to use the powers that you have given the executive in that law to deal with that serious problem. You were among the first in this country to recognize it.

Similarly, you have pioneered in seeking to improve specific areas of medicare coverage—such as the program for individuals suffering from end-stage renal disease. My comments on this laudable effort to increase effectiveness while controlling costs are appended to this statement.

Taken together, your activities have clearly placed this subcommittee in a key leadership position in the reform and improvement of our Nation's health care system. That is why it is so important that the hospital cost containment legislation reported by this committee should fully reflect your own deep concern with skyrocketing health care costs and should balance initiation of long-term reform with support of measures offering the potential for immediate and significant savings.

The revisions to S. 1470 that you are considering would go a long way toward achieving the necessary blend with the administration's short-term proposal. Your proposed expansion of coverage from just routine costs to ancillary service costs, and coverage of all payors not just Federal programs, are important steps in this direction.

As you know, the administration bill limits increases in total hospital inpatient revenues to an annual rate of about 9 percent in the first year of operations.

The program would cover the inpatient revenues of about 6,000 acute care and specialty hospitals, but exclude long-term, chronic care and new hospitals. We have also excluded Health Maintenance Organization hospitals because of the proven record of HMO's in reducing unnecessary hospitalization.

The basic limit would be set by a formula reflecting general price trends in the economy with an increment for increases in services. Each cost-based payer would apply the limits in interim and final payments, and would monitor hospitals for compliance with respect to its own subscribers.

The Human Resources Committee of the Senate has reported out a version of the administration's hospital cost containment proposal. The Health Interstate Subcommittee of the House Commerce Committee will report a bill out this week and the Health Subcommittee of the House Ways and Means Committee is continuing to mark up the administration's proposal.

With hospital inflation still holding steady at the wholly unacceptable rate of 15 percent per year, immediate congressional action on the administration's Hospital Cost Containment Act of 1977 still remains a national imperative.

By working together, we can find an effective equitable and workable solution to this critical and chronic national dilemma of rising health care costs. As I stated to this subcommittee in June, the end result of our current efforts must be strong controls that can be implemented with dispatch.

Health care providers now expect them, and the American people demand them. Nothing else will really do. It is no longer acceptable for us to offer proposals that will have their first positive effects in 2, 3, or even 4 years.

The American consumer has suffered too long, and so have the health care financing programs for which this subcommittee has responsibility.

Even in the few months since the hospital cost containment bill was introduced, the cost of an average hospital stay has increased from about \$1,300 to about \$1,400.

We have also had to raise, pursuant to law, the medicare inpatient hospital deductible for 1978 by 16 percent, from \$124 to \$144. Nobody wanted to do that, but, as you know, the law requires that the charge to the beneficiary must be related to program costs. Next year, the deductible could easily increase by as much as \$25 unless something is done.

Mr. Chairman, I must underscore again the enormous adverse impact on our health care system caused by continued delays in passage of hospital cost containment legislation.

In the 4 months since I last appeared before this subcommittee, the costs of health care in this country have risen \$7 billion, and about 40 percent of these are hospital costs alone.

If it takes another 4 months before this legislation is enacted and implemented, there will be an additional inflation of \$2.8 billion in hospital costs. Assuming the cost of this inflation is spread evenly among the Nation's 213 million citizens, that cruel inflation for just a 4-month period would constitute imposition of a \$13 tax on every man, woman, and child in America.

If the hospital cost containment program were in effect during the next 4 months, it would save about \$1 billion. And about \$370 million of that \$1 billion would represent savings to Federal taxpayers under medicare and medicaid alone.

That 4-month, \$370 million in savings is more than twice as much as we propose to spend annually on the proposed child health assessment program, 12 times more than our annual spending for research on drug abuse, and 15 times more than we will spend on the rural clinic bill recently passed by this subcommittee.

Our Nation's economy, our health care system, and, most importantly, our citizens simply cannot afford this mindless, inexorable spiraling of health expenditures that impoverish other needed health care programs and send the costs of medical care out of sight.

When I last testified before you on this issue, I identified for the committee over \$5 billion in annual savings that could be achieved in hospitals without reducing the quality of patient care. Since that time a number of investigations have revealed even more areas where savings have or could be achieved.

Some suggestions—let me give you some of the results of these studies, Mr. Chairman.

A recent Blue Cross and Blue Shield study in Michigan showed that a large number of patients are still admitted to hospitals on Friday and Saturday. These Friday and Saturday admissions have an average length of stay 1.7 days longer than admissions during the rest of the week. The study notes that:

The sheer number of patients and hospitals . . . suggest that many patients hospitalized on Friday and Saturday receive only custodial care . . . and not medical care on these days.

If we eliminated these seemingly unnecessary hospital days nationwide, we project \$2 billion savings in fiscal year 1977.

The Food and Drug Administration has estimated that up to 50 percent of hospital diagnostic X-ray exposure is unnecessary—up to 30 percent of the X-rays taken are merely to protect the physician against malpractice suits. For the X-ray units sold in 1976, the savings are estimated a \$70 million, if these units were used in an appropriate fashion.

We also continue to hear of the questionable medical efficacy of certain medical procedures. For example, a preliminary study reported in the New England Journal of Medicine suggests that for many patients suffering from chronic stable angina, coronary bypass surgery may be no more effective in prolonging life than conventional drug therapy. The cost of bypass operations is estimated to be \$1 billion in 1977. If the results of this preliminary study are confirmed, hundreds of millions of dollars could be saved through less frequent use of this expensive surgery.

In Atlanta, a group of neurologists installed a C.T. scanner across the street from a hospital which they knew would install a similar

scanner, with planning agency approval, only 3 months later. In that metropolitan area of only 1.5 million persons, there are already 17 CAT scanners. By comparison, Connecticut's certificate of need program has determined that eight scanners can meet the needs of the State's entire population of 3.2 million persons. Presently, only six scanners are in place in that State. This contrast dramatizes the need for tighter controls on reimbursement and capital investment and stronger areawide planning.

I testified in June, Mr. Chairman, that in the city of Los Angeles alone there are enough CAT scanners for the entire Western United States.

At the same time, we have seen a recent study of 120 hospitals that shows that their radiology and pathology specialists average \$100,000 per year or more. Those who are paid a percentage of charges billed by the hospital earn more than twice those receiving salaries. This practice, as the subcommittee has demonstrated, must be changed.

I would note, Mr. Chairman, that that study merely confirms what you perceived several years ago to be a serious problem relating to hospital costs.

In Orange County, Calif., hospitals are running at an average occupancy rate of 54 percent. This means, according to the executive director of the Orange County Planning Council that "two out of four hospital beds are unneeded." He stated further: "We have more in-patient resources in Orange County than we expect to need through the year 2025." Yet even in that county there are still millions of dollars committed to building new absolutely unneeded facilities in the future.

These examples—and I submitted other items of waste on a "fat list" that was appended to my June 7 statement—underscore the ineffectiveness of voluntary restraints so long requested by the hospitals. But the items from Atlanta and Orange County illustrate another aspect of the problem: They are symptomatic of the hospitals' tendency to play "keep up with the Jones'" using precious taxpayer dollars to wholly unnecessary equipment and facilities in order to compete with each other.

I would like, Mr. Chairman, if I may, to move to a portion of my statement near the end and comment briefly on the legislation and some of the revisions that the subcommittee has indicated they are going to consider in connection with its staff work.

There are certain provisions of S. 1470 that we think are examples of farsighted efforts of your subcommittee and can be helpful to put in the bill.

For example, the subcommittee has developed provisions for dealing with the problem of overcapitalization of the hospitals. The subcommittee's concern with the elimination of unnecessary hospital beds, as reflected in section 3 of S. 1470 in strengthening sanctions against institutions that provide services with unapproved capital facilities, with unapproved capital equipment, as shown in section 4, is shared by the administration.

The subcommittee has also focused attention to the need for alternatives to hospitalization, such as skilled nursing facilities.

Section 20 of S. 1470 allows the small, rural hospitals to receive reimbursement for furnishing services which if provided by a skilled

nursing facility, which would constitute posthospital extended care services for purposes of medicare and medicaid reimbursement. We think that is a fine provision, Mr. Chairman.

Finally, the special role played by this subcommittee in reforming the method of paying for services of hospital-based physicians such as radiologists, pathologists, and anesthesiologists, is worthy of note.

Your penetrating insight into the nature of abuses in this particular area, as well as their solution, can serve as a model for those who seek to improve the functioning of our medical care system. We support you fully in this regard.

In summary, Mr. Chairman, let me again recall your own words on May 5, 1977, when you introduced S. 1470, the proposed Medicare and Medicaid Administrative and Reimbursement Act.

You stated that S. 1470 represents a long-term basic structural answer to the problems of rising hospital costs, whereas the administration is going for a short-term interim gap on revenues to be in place only until a long-term solution can be established.

We recognize that our proposal is only a short-term measure, but it is necessary for the short term. It will serve the critical function of curbing the intolerable rise in hospital costs simply, quickly, and effectively.

We appreciate the efforts you have made as well as those of the Senate Human Resources Committee to increase the sophistication of our initial efforts in this area.

I continue to believe, Mr. Chairman, that our initial proposal is the best immediate alternative under present circumstances to the continued escalation of unnecessary hospital costs. I urge the committee to vote favorably on the initial proposal so we can provide the American taxpayers some quick relief from the oppressive and destructive inflation of hospital costs.

Mr. Chairman, I am also in closing—I would like to, if I may, read for the record a letter that the President sent you last night on this subject. The President sent similar letters to Chairman Rostenkowski of the Health Subcommittee of the House Ways and Means Committee and Chairman Rogers. He also sent a note to Senator Kennedy simply expressing appreciation.

Secretary CALIFANO. To Chairman Talmadge:

One of my most important priorities is to secure strong legislation to restrain the skyrocketing increases in health care costs. As subcommittees in both the House and Senate prepare to resume their work in this area, I wish to reaffirm my strong personal commitment to the administration's hospital cost containment legislation.

Last month, HEW announced that it was required to increase the deductible for hospital coverage under medicare from \$124 to \$144, reflecting rising hospital costs. These rising costs affect not only the elderly, but all Americans.

Today, 95,000 Americans will enter community hospitals. By the time that they leave the hospital, their care will have cost \$124 million.

Our people already spend for health care more than the people of any other nation, yet the cost of that care doubles every 5 years. The American people simply cannot afford yearly increases in their hospital bills of 15 percent or more.

The administration's hospital costs containment bill will restrain this escalation in hospital costs. It will save billions of dollars, not only in Federal and State budgets, but in the budgets of American families as well. This legislation is important in our twin efforts to restrain inflation and to improve the quality of health care for all Americans.

I deeply appreciate your leadership to this date.

Sincerely, Jimmy Carter.

Thank you, Mr. Chairman.

Senator TALMADGE. Thank you, Mr. Secretary, for an excellent statement.

You referred to the Orange County, Calif., hospitals. Senator Nunn's subcommittee—my colleague from Georgia—in Government Operations has been doing a good deal of investigation about some of the hospital waste. He found one particular hospital in Orange County, Calif., that maintained a full-time massage parlor for physicians with erotic pictures in the parlor, ostensibly for the purpose of getting the doctors to assign their patients to that particular hospital.

We hope that we can set up an ad hoc subcommittee of this committee and Senator Nunn's subcommittee to do some more investigation in matters of that kind. We have also found instances of massive fraud in medicare and medicaid practically throughout the country, and in some areas, allegedly the Mafia has moved in and started some HMO's.

We think these things cry out for correction.

Mr. Secretary, based on your close work with the two House subcommittees, do you anticipate that the full Ways and Means Committee and the Interstate and Foreign Commerce Committees will report out a hospital costs containment bill in this session of the Congress?

Secretary CALIFANO. Mr. Chairman, I think it depends on how long the session of the Congress lasts. The Interstate and Foreign Commerce Committee of the House, I do expect to report a bill out in this session.

The Ways and Means Committee, Chairman Ullman, is trying to get a bill out—I talked to him only about 2 weeks ago. That committee is also in the process of holding welfare reform hearings and has just completed social security legislation, which it will be bringing to the floor.

If the Congress ends this session in 2 weeks, I do not expect the committee to be able to report legislation out. If the congressional session extends for a longer period of time, I think they can do it.

The problem—I recognize the limitations on time—the problem is that the cost of a recess is so expensive, the cost of laying this legislation over to the next session is so expensive, and we think needlessly expensive for the American taxpayer. That I think it is the best I can report about actions in the House.

Senator TALMADGE. Even if the Congress remains in session another 5 or 6 weeks, do you anticipate the House action?

Secretary CALIFANO. Yes. I think if the Congress remained in session another 5 or 6 weeks we would be able to get action in the House of Representatives. We would certainly try with everything we have to get that action.

Senator TALMADGE. It would be passed through the House?

Secretary CALIFANO. That is what we are after, Mr. Chairman.

Chairman Rogers expects to report this bill out this week, out to the full committee. They have done an extensive amount of work.

Senator TALMADGE. I have been in touch with both Chairman Rogers and Chairman Rostenkowski, and they were not overwhelmingly optimistic that they could pass the bill this year.

Mr. Secretary, the administration bill, as I understand it, calls for the Department of HEW to submit a permanent plan for hospital cost containment in March of next year. What progress, if any, have you made to date toward the development of your long-term plan?

Secretary CALIFANO. Mr. Chairman, we have been working with your staff. I might say I have got a lot of suggestions and help from them.

We are trying to develop the kinds of economic data in HEW and the Government that would be needed on a continuing basis for a more sophisticated, long-run plan, not dissimilar, indeed, from the plan you have suggested. The kinds of data that we are trying to develop aim at the question of distinguishing among different types of hospitals. We are gathering data for that particular purpose, developing some kind of index that would be hospital-related as distinguished from the general CPI. I am not sure on the date of March 1978 that was written into the original proposed legislation. That was a time when we had hoped we would have this legislation in effect this year.

We have, in connection with the hearings and markups in the House and in the Senate Human Resources Committee devoted some resources to questions that were raised by Senators and Members of the Congress. That has diverted some of our resources, periodically, from the long-range solution.

I would like to go back and think through and provide you for the record whether or not we can still meet that March 1978 date.

Senator TALMADGE. We would appreciate it if you would do so.

[The following was subsequently supplied for the record:]

Throughout this year, the Administration has been working toward the development of a national health insurance program to be submitted to Congress next year that would have as one of its cornerstones long-term structural reform of the entire health care reimbursement system. That effort continues, enhanced by much that we have learned this year in the debate over the transitional program, S. 1391. However, meeting the original deadline was contingent upon the speed with which the Congress acted on our transitional proposal, since many of the resources expected to be devoted toward planning for the long term have now had to be diverted to work related to S. 1391. We continue to believe that if the Congress acts quickly and completes action on a transitional hospital cost containment program this session, the report suggested in our original proposal can be completed on time.

Senator TALMADGE. Mr. Secretary, apparently you are considering an alternative, a long-term hospital revenue control plan. Do you have any alternative proposals to offer in the place of your so-called short-term program in S. 1391?

Secretary CALIFANO. Not to deal with the short run, Mr. Chairman. The staff is looking at other alternatives over the long run. They have not come up to me. We would like, as I indicated in a general way in the legislation here, to incorporate even in short term legislation many of the provisions that are in your legislation.

We think many of them ought to be put into effect sooner as part of an immediate plan, and we would like to adopt as many of those as possible.

Senator TALMADGE. I am trying to determine how flexible you are on this flat 9-percent cap.

Secretary CALIFANO. I think we need the 9-percent cap. You asked whether or not that would provide enough calories for the hospitals.

That 9-percent cap would result in a reduction of \$2 billion in hospital expenditures, revenues, over what would happen at the current 15-percent rate.

I provided, last June, a list of \$5 billion of chocolate cream pies that I think the hospitals could stop eating. I provided this morning another \$3 or \$4 billion of potential savings in terms of waste.

I do not think that Orange County is an isolated example in the context of having an outrageous number of hospital beds. I think every hospital bed is like another dessert that a hospital does not need, that it does not use. We should try to eliminate those as promptly as possible.

I think that 9 percent gives the hospital plenty of calories for the next few years. They still will not be as lean and trim as they should be to provide the highest quality care.

Senator TALMADGE. I agree with you. I think that many, many hospitals are very inefficiently run, but I also think that many of them are very efficiently run, and it seems to me that a flat 9-percent cap that denies the efficient and rewards the inefficient—would you comment on that?

Secretary CALIFANO. Mr. Chairman, I think that those who are operating presently within a 9-percent limit are some of the finest hospitals in this country. Some of the smallest hospitals in the country are operating in that range as well.

When I testified in June, I submitted the percentages of different kinds of hospitals in different parts of the country that were operating at or below 9 percent now.

Senator TALMADGE. Are those hospitals doing that consistently, or just for 1 year? I believe we asked you to send us a list of the hospitals. I do not believe we have received them yet.

Secretary CALIFANO. You have not?

Senator TALMADGE. No, sir.

Secretary CALIFANO. You will have a list of those hospitals, Mr. Chairman, within the week.¹

Senator TALMADGE. Thank you, sir.

Secretary CALIFANO. Also to the extent to which there are trends involved. I am sorry about that, Mr. Chairman.

Senator TALMADGE. Senator Dole?

Senator DOLE. I appreciate your statement very much. Again, you indicate the need that we do something and I assume you would like to have it done this year, if at all possible.

Secretary CALIFANO. I would, Senator. I realize the realities of the congressional schedule, but at least two committees, the Human Resources Committee here in the Senate and the Interstate and Foreign Commerce Committee will have been able to act before Congress goes home, and I would hope that this committee would.

I realize that this committee has a lot of other items on its workplate that other committees of the Congress do not have, the energy problems, the social security legislation, which also are very important. It just seems to me, if there were some way to act, at least to me, with short-run legislation, there is so much to be saved even during a brief period of 4 months, just in medicare premiums. If we are half-

¹ See appendix on p. 387.

way into the fiscal year before the committee moves, that is at least \$10 and probably more of increased premium that everybody in the medicare program is going to have to pay, an absolutely unnecessary \$10.

Senator DOLE. I know that you have probably pursued every possible route to success to find some way to deal with the problem. Certainly I cannot suggest anything, but perhaps maybe a summit meeting, getting all of these different committees together and trying to hammer out something.

I know Senator Talmadge is very reasonable, and I am just as reasonable as he is.

Senator TALMADGE. If the Senator would yield at that point——

Senator DOLE. Yes.

Senator TALMADGE. I think I would be remiss in my duty if I did not compliment Senator Dole for his complete and thorough cooperation in all of these bills relating to cost control, fraud, and abuse.

He has been not only a cosponsor but a very strong, active, enthusiastic supporter.

Secretary CALIFANO. Mr. Chairman, let me join in that. I think that Senator Dole has clearly indicated repeatedly in all the work we have done in this area in the last 8 months that this is, in no way, a partisan problem. This is a difficult, complex problem for this country. It is clearly unnecessarily costly, and we are all active in trying to do something about it, and we appreciate that very much.

Senator DOLE. If we could stir up as much interest on this as we seem to have on the Panama Canal, maybe we could get enough focus on it. It is really a mammoth problem.

I do not know where it ends. I have the same reservations as Senator Talmadge does on the cap, but there ought to be some middle ground there where we come together. Our next witness, Senator Schweiker, has a little different approach, which has some appeal. I do not know if he specifically commented on S. 1470. His plan is a proposal advanced by Senator Schweiker and Senator McIntyre from New Hampshire.

Secretary CALIFANO. I would note, with respect to that proposal, that our feeling is that it is too lenient with respect to State commissions. There are some State commissions that clearly have demonstrated that they can do the job.

The commission in Massachusetts which has held the costs to 9 percent; the State commission in Maryland, are only two of these.

In fact, we have learned from those commissions a great deal that is incorporated in the legislation that we proposed.

To provide carte blanche to a State to handle hospital costs with an untried commission and an untried plan in the first year or two of operation, we think it is too costly to the citizens of that State and too costly to the taxpayers generally since the Federal Government picks up so much of the cost, and incurs unnecessary risks in terms of high hospital costs.

We would like to have them have enough experience so it is working. It is not an easy thing to do. There are States where cost containment efforts have not worked in the past.

I have had conversations with Senator Schweiker about this. I realize he has given a great deal of thought to this subject and has

a different view with respect to that part of it. I am sure he will make the case for his point of view; that is our point of view.

Senator DOLE. I assume that there has been some effort, too, to work it out with the industry. We also have Mr. McMahon, the president of the American Hospital Association, with us today.

Are you having any conferences with representatives of this group, trying to find some common ground?

Secretary CALIFANO. We had many conferences with the hospital industry and other portions of the health care industry before we sent this legislation up. We are constantly talking to them. They have, quite naturally, what we perceive to be a relatively narrow point of view.

We believe that hospitals can easily accommodate to the provisions in our legislation. A large percentage already have.

We believe that it is not in the public interest to continue to pay hospitals enormous amounts of money when waste is so rampant, where there is so much being spent that is unnecessary, that does not contribute one iota to the quality of the health care of American citizens.

Mr. Derzon, I would note, who heads the Health Care Financing Agency, went to the annual American Hospital Association meeting and talked to them. We have urged them to try and turn their efforts to more constructive cooperation with our legislation. The Hospital Association is doing some fine work in promoting the children's immunization program, to get the children of this country immunized.

From our point of view, we would hope that Mr. McMahon would turn more of his lobbyists here on Capitol Hill to the problem of childhood immunization and away from the problem of trying to keep the dessert and candy pouring into the hospitals of the United States.

Senator DOLE. In the administration bill acted on by the Committee on Human Resources, there is no indication, at least by the staff, when the temporary cost control program would terminate, if we passed that legislation. How long do you believe that it would be in effect? How long would it take to integrate the short-term program approach with the long-term program that you are developing?

Secretary CALIFANO. That also was indefinite in our legislation. My judgment is that we are talking about 3 to 5 years to get in place a more sophisticated hospital cost containment program. The timing in the longer run is also related to how the Executive and the Congress ultimately decide to deal with the issues of national health insurance and over what period of time.

As I said, I think the kinds of suggestions in the legislation that you and Senator Talmadge had discussed, a more sophisticated breakdown of hospitals, a more sophisticated measure of inflation, are very healthy things and I would like to get there as fast as we can, and indeed, I have asked that steps be taken to try and develop the data necessary to provide for that kind of a sophisticated breakdown. It is clearly unfortunate, and indeed surprising to me, that we did not have that data and have not been developing it over the last several years. Asking that something be done as said by the Secretary of HEW does not always mean it is being done.

Senator DOLE. How about the Congressional Budget Office estimate that by 1982 the revenue increase for hospitals would be less than the estimated rate of inflation in the economy. That would amount to almost a freeze on hospital revenues, according to these estimates.

I should note that I do not always agree with the Budget Office.

Secretary CALIFANO. I know that.

Dr. DAVIS. We have several differences with the Congressional Budget Office estimates. The actuaries project somewhat different figures than the Congressional Budget Office.

Senator DOLE. Maybe you could supply those for the record.

Dr. DAVIS. I would be happy to do so.

[The following was subsequently supplied for the record:]

ADMINISTRATION COMMENT ON CONGRESSIONAL BUDGET OFFICE PROJECTIONS

The Committee requested the Department's comments with respect to the Congressional Budget Office estimate that under the Administration's proposal eventually hospital revenues would be allowed to grow at less than the rate of inflation in the general economy. Both the Administration and the CBO have prepared five-year projections of general inflation (increases in the GNP deflator) and the limit that would result under S. 1391. Under the assumptions of both the Administration and CBO, during the five-year period between 1978-82, hospitals would be allowed revenue increases more than adequate to meet the inflation expected during that period.

Under the Administration's assumptions, the estimated increase in the GNP deflator (compounded) is expected to be 28.3 percent during that period and the sum of the annual limits under the hospital cost containment program (no compounding) is expected to be 39.5 percent. Under CBO assumptions, the expected increase in the GNP deflator would be 30.3 percent while the cumulative allowance of the Administration limits under S. 1391 would be 39.7 percent.

DIFFERENCES IN THE ASSUMPTIONS USED BY THE OFFICE OF THE ACTUARY (DHEW) AND THE CONGRESSIONAL BUDGET OFFICE IN PROJECTING SAVINGS UNDER THE HOSPITAL COST CONTAINMENT ACT OF 1977

1. Differences of a significant magnitude in the projected increases in the GNP deflator (see Tables). These differences result in different estimates of the revenue increase limits.

2. Differences in the "current policy" projections for total non-Federal inpatient hospital expenditures. The differences are not large for individual years, but over the entire five-year period they do have a pronounced effect on the total savings.

3. Differences in the assumptions concerning the additional increase in hospital expenditures in each year due to (a) adjustments for changes in the volume of admissions, (b) exceptions for expenses generated by approved capital expenditures, and (c) the effect of the optional wage pass-through. The Congressional Budget Office assumes a 1.0 percent additional increase for changes in admissions volume and .9 percent for the exceptions process for each year. The Office of the Actuary assumes the following percentage increases:

	Volume adjustment	Capital spending exceptions	Wage pass-throughs	Total additional increase
Fiscal year:				
1978.....	1.5	0.6	1.7	3.8
1979.....	1.5	.5	2.1	4.1
1980.....	1.5	.6	1.8	3.9
1981.....	1.5	.7	1.7	3.9
1982.....	1.5	.8	1.6	3.9

On average, the Office of the Actuary assumes an additional increase of about two percentage points over that assumed by the Congressional Budget Office. This has a substantial cumulative effect on the calculation of the basic limit and on the savings expected to be realized under the program.

ESTIMATED SAVINGS UNDER THE HOSPITAL COST CONTAINMENT ACT OF 1977 FOR TOTAL
NON-FEDERAL SHORT-TERM INPATIENT HOSPITAL EXPENDITURES

ESTIMATES AND ASSUMPTIONS OF THE OFFICE OF THE ACTUARY, SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE¹

	Projected spending (billions)			Annual limit	Expected percentage change in GNP deflator	
	Current policy	Under HCCA	Net savings		12 mo ²	24 mo ³
Fiscal year:						
1978 -----	\$54.6	\$51.6	\$3.0	9.0	6.1	5.6
1979 -----	63.0	58.1	4.9	9.5	5.8	6.1
1980 -----	72.4	64.2	8.2	7.5	5.2	5.8
1981 -----	82.9	70.7	12.2	7.0	4.4	4.8
1982 -----	94.1	77.1	17.0	6.5	4.1	4.4
Total for 1978-82 ..	367.0	321.7	45.3			

¹ Assumes Oct. 1, 1977, effective date for all hospitals.

² Period ending June 30 preceding start of relevant fiscal year.

³ Period ending Dec. 31 preceding start of relevant fiscal year.

ESTIMATES AND ASSUMPTIONS OF THE CONGRESSIONAL BUDGET OFFICE¹

	Projected spending (billions)			Annual limit	Expected percentage change in GNP deflator	
	Current policy	Under HCCA	Net savings		12 mo ²	24 mo ³
Fiscal year:						
1978 -----	\$55.8	\$52.4	\$3.4	8.7	5.52	5.87
1979 -----	63.7	57.7	6.0	9.3	6.22	5.55
1980 -----	72.8	62.3	10.5	7.6	5.40	6.00
1981 -----	83.1	66.5	16.6	7.1	5.02	5.39
1982 -----	95.2	70.7	24.5	7.0	5.06	5.12
Total for 1978-82 ..	370.6	309.6	61.0			

¹ Assumes Oct. 1, 1977, effective date for all hospitals.

² Period ending June 30 preceding start of relevant fiscal year.

³ Period ending Dec. 31 preceding start of relevant fiscal year.

Senator DOLE. Is it fair to say that your estimates are in conflict with theirs? Do you disagree with their estimates?

Dr. DAVIS. The different assumptions of what will happen to the prices in the economy, what the hospital expenditures are on which they are based. We would be happy to lay out the methodology.

Senator DOLE. Have you had an opportunity to review the article in U.S. News this week?

Secretary CALIFANO. I read it quickly. I think that it reflects, as you indicated, a national concern with all kinds of health care costs. I think it does reflect, from the interviews of some of those doctors that there are many, many doctors in this country concerned about this problem.

Senator DOLE. What about the criticism that your plan fails to address regional and institutional variations in hospital costs? Senator Talmadge tries to adjust that in his legislation. Have you made any attempts to resolve this matter in the long-term plan that is to be submitted in 1978?

Secretary CALIFANO. We will try. I am not sure whether the way to deal with it is solely regional or by class of hospital. We are looking at both of those, and whether both of those kinds of factors should be included.

I would say that we do provide a wide enough spread in percentages to deal with regional variations. Also, as far as capital expenditures are

concerned, we permit the States to allocate the amount of capital expenditures to which we limit hospitals in our legislation themselves, which can also take care of some of the capital needs. It might vary, depending on different parts of the country and depending on the problem on health services or beds needed.

I guess I should note that one of the things we have to keep in mind, particularly as far as rural health is concerned, is that this is not the only program. There are rural health initiatives that we are pursuing. One is the physician extender legislation which this committee reported out and the House reported and which we should have this year.

Senator DOLE. You indicated you were—and I am certain you are right—about to have some new fraud and abuse legislation, and that there is an effort at HEW to try to track down some of the more prevalent abuses. I notice them being revealed publicly and I assume there are many others that you are working on.

Secretary CALIFANO. Senator Dole, we started what we now call "Project Integrity." We were originally going to call it "Project 100." It is just medicaid, it is just doctors and pharmacists. We do not single them out, we just happened to have them on computer tapes in the appropriate way, and we took the computer tapes and ran doctors' billings against a host of obviously highly-suspect activities: Taking out the appendix from one person two or three times in the same year, performing an abortion on a woman after a hysterectomy had been performed in the same year, a whole host of procedures like that, and with respect to pharmacists prescribing literally 50 or 60 or 100 pills per day for several days—in one case, 200 days—and being paid for it.

That project, which we thought we might find 50 doctors and 50 pharmacists in this country, we now have 2,500 cases like that, about 1,400 doctors and pharmacists throughout the country. We have now stopped. We have stopped now at 50 cases, per se, just to deal with that kind of item.

So there are problems there. We are also trying to develop the same kind of material for medicaid and for hospitals and other providers that we can run computer tapes of similar activities there. The program is very vulnerable to fraud and error, and we are trying to clean that up.

I have talked to the chairman about something else. In this area we do have, along with Attorney General Bell, an interest in the Justice Department in prosecuting these cases. For a long time, even when HEW in the past would turn out some cases like that, it was not popular, not a sexy thing for U.S. attorneys to prosecute cases in this area, and now it is.

We have also entered into a \$6 million program in New York with Heinz, who has been a very effective prosecutor up there in New York State, an attempt to develop some models of how to move fast on medicaid fraud and abuse.

It is imperative that we not only uncover these cases, but that, once they are uncovered, cases be certain that they have not paid. This system grew absolutely like topsy. There are now 5.2 million student loans out there, 900,000 new student loans every year, and a much smaller number go off, because they persist for many, many years. It has not been well-computerized; much of it was not computerized

at all. The program was such that we had no way of knowing when student loans were being defaulted on, and then, when they were defaulted on, as I said, I discovered a couple of months ago that nobody was ever sent a bill.

Senator DOLE. If there is anybody in the room or anybody listening that wants to pay their loan, they could get in touch with you?

Secretary CALIFANO. Absolutely.

Senator DOLE. It points out the problem that you must have and one that Senator Talmadge is trying to address, in the previous legislation you referred to the medicare and medicaid fraud and abuse bill. If we could at least alert the American people I think that once they focused on some abuses that are in the program, I just think we will have more impact, and maybe speedier action.

As I take it, on the end-stage renal disease program—we are going to have some witnesses a week from Friday—your statement will be made a part of the record. Do you have some additional comments to make?

Secretary CALIFANO. Yes, I do. We are basically in support of what the committee is trying to do in that area. We think it is important to provide as much encouragement as possible for dialysis treatment, in the home.

Senator DOLE. I have been told that the death rate is very high in home dialysis. You probably have studies that would indicate what the facts are?

Secretary CALIFANO. We can submit those for the record.

[The following was subsequently supplied for the record:]

The only nationwide comparative study on the mortality/survivorship of home versus facility dialysis patients was performed by the National Dialysis Registry. This analysis, which covered the years 1972, 1973, and 1974, reported survival rates for home dialysis patients of 93.9 percent, 86.2 percent and 78.6 percent at 1, 2 and 3 years, respectively. The reported survival rates for facility dialysis patients during this period were 85.5 percent, 77 percent and 71.4 percent at 1, 2 and 3 years, respectively. It is important to note, however, that no effort was made to address or adjust for any difference in severity of illness and/or potential for rehabilitation among the patient populations.

In addition to the above statistics, in a March 1976 article entitled "Self Hemodialysis—The Optimal Mode of Dialytic Therapy", in the "Archives of Internal Medicine," the authors reviewed current literature related to the question as to which form the delivery of dialysis should take. The authors assessed several studies, some of which showed a lower mortality rate for home dialysis as compared to center dialysis and other studies which showed the opposite. They concluded overall that home or self-care dialysis patients have better survival rates, and that when economic, rehabilitation, and other factors are considered, self-dialysis at home or in-center, as opposed to in-center limited care dialysis is the preferred modality of treatment for the majority of patients.

A future source of nationwide data on patient mortality and morbidity associated with the various modes of treatment will be the End-Stage Renal Disease Medical Information System, which is presently collecting information.

Secretary CALIFANO. I would say, during the national health insurance hearings I held at HEW last week, a woman testified whose husband was getting dialysis treatment at home and had been getting it for well over a year, about the tremendous financial burden that was being imposed upon her for doing that.

Senator DOLE. For the home?

Secretary CALIFANO. Because she was doing it in the home, what a difference it made in the costs they had to bear, rather than having

it done in the hospital, even though it was less expensive to do it in the home. I might provide her name to your staff, because she was a very impressive witness.

Senator TALMADGE. I would like to point out that that bill was originally introduced by Senator Long last year and the House has merely improved on his version of the bill.

Mr. Secretary, under the staff recommendation of the modification of our bill, the revenue limits would be alined on the basis of the 2-year moving average. The purpose of that is to smooth out the unusual nonrecurring variations from one year to the next.

Does the administration bill recognize a problem of year-to-year variation which our proposal tries to deal with?

Secretary CALIFANO. We permit a carryover in our legislation. What I would like to do is see if we could not come to some agreement on how to handle that problem.

Senator TALMADGE. As I understand it, that is a carryover if you are under the limit, but no carryover if you are above the limit?

Secretary CALIFANO. That is correct, Mr. Chairman. But I am willing to have us sit down and see if we cannot find a way to deal with the problem that you are addressing.

Senator TALMADGE. Mr. Secretary, both the administration bill and the bill enacted by the Committee on Human Resources include special provisions to exempt certain hospital wages from revenue limits. Could you explain to the committee why such exemptions are justified?

Secretary CALIFANO. Mr. Chairman, we included in our bill legislation which provided that if wage increases above the 9 percent were granted, that they could be passed through.

We also provided, under our legislation, if wage increases below 9 percent are achieved, then that is all, if you will, that the hospital can account for. If it is a 5-percent wage increase, they would not request any special treatment.

The Committee on Human Resources provided for the passthrough if the wage increase were above 9 percent, but they also provided that when the actual wage increase was only 6 or 7 percent the hospital would be allowed credit only for the amount actually granted.

We set our provision in order to take care of those situations in which there are particularly low-paid workers in hospitals who are being brought up to higher wages in some areas.

On the average in the country in the past 7 years, the wage increase for hospital workers has been about 7.2 percent and we do not anticipate a major problem in that area. However, we thought we had a responsibility and it made sense from a public policy point of view to take care of the particularly low-wage hospital worker who would get an increase, who might need an increase of in excess of 9 percent in order just to be brought to the poverty level.

Senator TALMADGE. Frequently, the differences in salary between supervisory and nonsupervisory personnel is minimal. Through overtime, a nonsupervisory employee could make more than a supervisory employee. Would not such a situation cause havoc in hospital management and personnel practices?

Secretary CALIFANO. I do not think it would. Maybe Dr. Derzon, who was an administrator in hospitals in New York and California and now runs HCFA, maybe he would like to comment on that.

Mr. DERZON. The administration bill does not tell a hospital what it can or cannot pay employees. It merely says that one group of hospital employees' wages, should they be in excess of 9 percent, can be treated on an exceptional basis.

This does not prevent the hospital from raising the salaries of all of its employees.

Senator TALMADGE. It does say you cannot pass through the salary increases of supervisory personnel. You can pass through the nonsupervisory personnel.

Mr. DERZON. That is correct; in excess of 9 percent if it is necessary.

Senator TALMADGE. Mr. Secretary, would it not be helpful if you could submit a full report on your evaluation of hospital employee wage levels for the record, and it would be appreciated if you would deal in that report with the various issues that Senators Schweiker, Hatch, and Hayakawa have raised in their minority view in S. 1391.

Secretary CALIFANO. We will do that.

[The following was subsequently supplied for the record:]

ADMINISTRATION POSITION ON THE SCHWEIKER BILL, S. 1878

This bill, in essence, would establish a system of 50 different State programs as the vehicle for health care cost containment.

The Administration's program, as introduced in S. 1391, provides that hospitals in States with experience that demonstrates an ability to contain cost increases may be exempted from the Federal system as long as the State program is in operation. Additional States could receive such a waiver in the future, but only after they had at least one year's experience operating in conjunction with the Federal program. Hospitals participating in HEW reimbursement experiments or demonstrations could be exempted as well in order to further objectives of our experiments.

Our major objection to S. 1878 is that, because of the start-up time involved, if new States which do not now have programs were to apply under the bill, the creation of new administrative and grant mechanisms would delay for at least two (2) years any practical assistance.

The purpose of these provisions is to strengthen those State programs that are already in effect and provide an environment that will foster new State programs, but in a way that promises the States the greatest chance for success.

EVALUATION OF HOSPITAL WAGE DATA

The minority members of the Committee on Human Resources view the mandatory wage pass-through as the major defect in that Committee's revisions to S. 1391, the Hospital Cost Containment Act of 1977. They feel that such a broad provision as the one approved by the Committee goes beyond the Committee's stated intent of not requiring that non-supervisory workers bear a disproportionate burden in cost containment efforts. They cite data from various sources to support their case. What follows is a summary of the available data as used by the Administration in the development of its provision for the optional wage pass through included in S. 1391 as originally introduced. These data demonstrate: (1) that the wages of these workers are below those of the non-supervisory workers in other industries, and (2) that increases in the salaries of non-supervisory hospital workers have not been the primary cause of hospital inflation in the past.

1. The hourly wage of non-supervisory hospital workers is about 86 percent of the hourly wage of private sector non-agricultural workers in other industries. In 1976 non-supervisory hospital workers earned an average of \$4.18. Private sector non-agricultural industry workers earned an average of \$4.87 an hour. The private sector non-agricultural industry workers group was used because it is the broadest group which includes hospital workers and excludes a largely underpaid group of farm workers.

HOURLY EARNINGS—NONSUPERVISORY EMPLOYEES

	Hospitals	Private sector nonagricultural industry	Ratio
1969-----	\$2.57	\$3.04	84.5
1970-----	2.79	3.22	86.6
1971-----	2.96	3.44	86.0
1972-----	3.08	3.67	83.9
1973-----	3.22	3.92	82.1
1974-----	3.45	4.22	81.8
1975-----	3.83	4.54	84.4
1976-----	4.18	4.87	85.8

Source: Bureau of Labor Statistics.

2. The annual rate of increase in non-supervisory employee hourly earnings has averaged 7.2 percent in the years 1969-76. This period excludes the 1965-68 period during which the most severe of the wage disparities between hospital workers and others were eliminated, in part as a result of passage of Federal health financing legislation and partly due to the passage of general labor legislation. The comparable figure for private sector non-agricultural industry is 7.0 percent. The figure for hospital workers is far below the first year's limit of about 9 percent which would be the limit on hospital inpatient revenue increases under S. 1391 as proposed.

ANNUAL RATES OF INCREASE (NONSUPERVISORY EMPLOYEES)
[In percent]

	Hospitals	Private sector nonagricultural industry
1969-70-----	8.6	5.9
1970-71-----	6.1	6.8
1971-72-----	4.1	6.7
1972-73-----	4.5	6.8
1973-74-----	7.1	7.7
1974-75-----	11.0	7.6
1975-76-----	9.1	7.3
Average 1969-76-----	7.2	7.0

Source: Bureau of Labor Statistics.

The specific data cited from the Feldstein and Taylor study were the subject of a note to their report on "The Rapid Rise of Hospital Costs" which explains the discrepancy between the figures cited by the Administration and those cited in their report and in the Committee on Human Resources minority views. The authors noted that the source of the earnings statistics for hospital employees (cited by the minority members) was the American Hospital Association survey of all salaried hospital employees, including supervisors, some physicians, and hospital administrators. The Bureau of Labor Statistics earnings statistics with which these were compared covered only production and non-supervisory workers. If weekly or hourly earnings of production and non-supervisory workers in hospitals were compared with those of all production and non-supervisory workers, 1975 earnings of hospital workers would be less than for all U.S. workers. In December 1976, average hourly earnings for hospital workers were \$4.34, compared to \$5.02 for all private sector workers. A ratio of average hourly earnings for hospital vs. non-hospital workers of 86 percent.

More significant, however, is the fact that Feldstein and Taylor recognize that while the greater increase in the average earnings of hospital employees has frequently been cited as the primary cause of the unusually rapid rise in hospital costs, such an interpretation is not supported by a more detailed examination of the evidence . . . a substantial part of the increase in labor cost per patient day is due to the rising number of employees. The Administration's proposal does not adjust for increases in labor intensity. The optional pass-through as proposed by the Administration applies only to wage increases.

In summary, the Administration supported an optional wage pass-through because non-supervisory hospital workers earn less on the average than other workers, the rates of increase in salaries paid to non-supervisory hospital workers have been comparable to those of other workers in the past, and increases in labor intensity, not only salary increases, account for a substantial part of inflation in the labor costs of the hospital sector. Further, the exempted group of workers would otherwise be most vulnerable.

It is conceivable that a hospital could comply with the limits of freezing wages, and not making any of the needed changes in their mode of operation; however, this would be contrary to the intent of the legislation.

Senator TALMADGE. Mr. Secretary, the class of payor approach in the administration bill seems to create a number of equity and administration problems. Why did you adopt this approach, and what alternatives are there to your class of payor approach?

Secretary CALIFANO. I am sorry, Mr. Chairman, I missed the last part of that question.

Senator TALMADGE. No. 1, why did you adopt the class of payor approach?

Dr. DAVIS. The way the administration's bill is structured it would limit each major kind of payor to the 9-percent increase. Medicare would not pay more than 9 percent than they paid the previous year; medicaid would not pay more than 9 percent than they paid the previous year; similarly for Blue Cross and all charge payors.

I think the situation you get into when you get to the 9 percent is total is they might hold down medicaid to 5 percent and then let their private payors go up 20 percent. We all think that would be acceptable.

The other problem you could go into if you go to this broader settlement basis would be that every payor wants to wait until everybody else has settled, so that you would get into a game between medicare, medicaid, Blue Cross, private, each waiting for the others to settle first. It would be administratively difficult.

Senator TALMADGE. It seems to me the difficulty would be that the payors would not know what the rate would be until after the end of the year.

Dr. DAVIS. Each payor would know at the end of the year what they are obligated to pay under a situation, because it is 9 percent for each major payor. So a medicare intermediary at the end of the year totals up what the revenues had been in the previous year and indicates what the allowable rate of increase is.

Senator TALMADGE. The hospital would have already made these payments, then they would have to recompute at the end of the year a repayment that they made to every individual; would they not?

Dr. DAVIS. No; it is on the total for all of the patients covered by medicare. It is not a patient-by-patient basis. In total.

Senator TALMADGE. Suppose you have 100 different insurance companies involved?

Dr. DAVIS. In the case of the insurance companies, what we require is the hospital not collect more than 9 percent on average from all private paying patients, self-paying or those covered by commercial insurance policies than they collected the year before.

The medicare intermediary advises them on this. They are required, if they are over, after the year to put that excess in an escrow account. If they are under in future years, they can draw on it.

Senator TALMADGE. They would have to figure out who paid and recompute that and recover the money they paid; would they not?

Dr. DAVIS. No, they are not required to do that. If they had excess charges, we do not require them to pay back money to individual patients. We simply say, this year you are over; next year you have to be under to draw on those funds.

Senator TALMADGE. What alternatives is there to your class-of-payor approach?

Dr. DAVIS. I am sorry, Mr. Chairman. We favor sticking with the cost-of-payor approach.

Senator TALMADGE. You do not have any alternative to suggest whatever?

Dr. DAVIS. We think it is important to take that approach, yes, sir.

Secretary CALIFANO. The only other thing I would add to Dr. Davis' comments are, one of the reasons we chose that related to administrative efficiency, to our desire to provide a system in which we would not have to keep extra pieces of paper and would not have to impose another recordkeeping system, something that I think—when payors have testified will indicate is that it does make life easier for them.

Senator TALMADGE. Mr. Secretary, in previous testimony, hospital spokesmen have objected to the provisions in the administration bill which link allowable increases in revenues to changes in the general inflation rate of the economy. They allege that the prices of the goods and services purchased by hospitals change faster than the rates indicated by the price indicators in the administration bill.

How do you respond to these criticisms?

Secretary CALIFANO. I think that those particular criticisms are unwarranted. First of all, while permitting an increase of $1\frac{1}{2}$ times the cost of living, if you put the bill into effect immediately hospitals would still—it would only reduce hospital revenues by \$2 billion in the first year, and there are, as I indicated, several billions of dollars of what we would all agree would be waste. So it is an easy number to meet.

Second, we do not, at this point in time, have a sophisticated enough economic data base to judge what hospital costs really are, what truly are different about hospital costs from other costs, besides tremendous increases and that turns out to be an unrestricted way of purchasing technological equipment.

Senator TALMADGE. I believe New York State has hospital cost indexes that show differences, do they not, Mr. Derzon?

Mr. DERZON. Yes, sir, as does Massachusetts. It is my impression, however, if you take those indices in those particular States, they are not substantially different in terms of the total percentages than using the formula proposed in the administration bill.

My own feeling, as a former hospital administrator, is the increasing cost of care in an institution tends to relate to changes in intensity of technology. That probably results in as much of the discretionary increases as any other thing.

This bill leaves some room, certainly, for the addition of new technology and that basically it would allow the hospital administrator a reasonable opportunity to deal with the inflation of goods and services.

Given the outside inflationary factors, then, he would have to make choices, along with his medical staff, about the other things he does in the institution.

Senator TALMADGE. Mr. Secretary, I believe Senator Dole has already asked you to comment on Senator Schweiker's hospital cost containment bill, S. 1878. Would you please submit that for the record?¹

Secretary CALIFANO. Yes, I will, Mr. Chairman. I will submit more detailed comments for the record. I would also note as an addendum to Mr. Derzon's statement that Massachusetts, for example, they have been setting that rate at 9 percent, which is one and a half times the cost of living, basically.

Senator TALMADGE. Senator Dole?

Senator DOLE. I have no questions.

Senator TALMADGE. Thank you very much, Mr. Secretary and your associates. We appreciate very much your being with us and your contributions to our deliberations.

Secretary CALIFANO. Thank you, Mr. Chairman.

[The prepared statement of Secretary Califano follows:]

STATEMENT BY JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION,
AND WELFARE

Mr. Chairman, I appreciate the opportunity to appear before your distinguished Subcommittee on Health to discuss the revised version of S. 1470, your Medicare-Medicaid Administrative and Reimbursement Reform Act, the President's Hospital Cost Containment bill, and the Hospital Cost Containment bill reported out by the Human Resources Committee.

The recent modifications in S. 1470 demonstrate the intention of this Subcommittee to continue its outstanding role in identifying serious problems and devising needed reforms in the nation's health care system.

Although there is no higher national priority in health than controlling the precipitous and intolerable escalation of hospital costs, this Subcommittee has shown by its extraordinary work that initiatives in the hospital cost area are only one aspect of the overall need for reform in the delivery and financing of health services.

For example, this Subcommittee's long-standing effort to secure passage of much needed reforms to curb fraud and abuse in the Medicare and Medicaid programs is about to reach fruition with the Presidential signing of legislation that does you great credit.

Similarly, you have pioneered in seeking to improve specific areas of Medicare coverage—such as the program for individuals suffering from end stage renal disease. My comments on this laudable effort to increase effectiveness while controlling costs are appended to this statement.

Taken together, your activities have clearly placed this Subcommittee in a key leadership position in the reform and improvement of our nation's health care system. That is why it is so important that the hospital cost containment legislation reported by this committee should fully reflect your deep concern with skyrocketing health care costs and should balance initiation of long-term reform with support of measures offering the potential for immediate and significant savings.

The revisions to S. 1470 that you are considering would go a long way toward achieving the necessary blend with the Administration's short-term proposal. Your proposed expansion of coverage from just routine costs to ancillary service costs, and coverage of all payors not just Federal programs, are important steps in this direction.

As you know, the Administration bill limits increases in total hospital inpatient revenues to an annual rate of about nine percent in the first year of operation.

The program would cover the inpatient revenues of about 6,000 acute care and

¹ See p. 151.

specialty hospitals, but exclude long-term, chronic care and new hospitals. We have also excluded Health Maintenance Organization hospitals because of the proven record of HMO's in reducing unnecessary hospitalization.

The basic limit would be set by a formula reflecting general price trends in the economy with an increment for increases in services. Each cost-based payer would apply the limits in interim and final payments, and would monitor hospitals for compliance with respect to its own subscribers.

The Human Resources Committee of the Senate has reported out a version of the Administration's hospital cost containment proposal. The Health Interstate Subcommittee of the House Commerce Committee will report a bill out this week and the Health Subcommittee of the House Ways and Means Committee is continuing to mark-up the Administration's proposal.

With hospital inflation still holding steady at the wholly unacceptable rate of 15 percent per year, immediate Congressional action on the Administration's Hospital Cost Containment Act of 1977 still remains a national imperative.

THE CONTINUING NEED FOR IMMEDIATE CONTROL OF HOSPITAL COSTS

By working together we can find an effective equitable and workable solution to this critical and chronic national dilemma of rising health care costs. As I stated to this Subcommittee in June, the end result of our current efforts must be strong controls that can be implemented with dispatch.

Health care providers now expect them, and the American people demand them. Nothing else will really do. It is no longer acceptable for us to offer proposals that will have their first positive effects in two, three or even four years.

The American consumer has suffered too long, and so have the health care financing programs for which this Subcommittee has responsibility.

Even in the few months since the hospital cost containment bill was introduced, the cost of an average hospital stay has increased from about \$1,300 to about \$1,400.

We have also had to raise, pursuant to law, the Medicare inpatient hospital deductible for 1978 by 16 percent, from \$124 to \$144. Nobody wanted to do that, but as you know, the law requires that the charge to the beneficiary must be related to program costs. Next year the deductible could easily increase by as much as \$25 unless something is done.

Mr. Chairman, I must underscore again the enormous adverse impact on our health care system caused by continued delays in passage of hospital cost containment legislation.

In the four months since I last appeared before this Subcommittee, the costs of health care in this country have risen \$7 billion, and about 40 percent of these are hospital costs alone.

If it takes another four months before this legislation is enacted, and implemented, there will be an additional inflation of \$2.8 billion in hospital costs. Assuming the cost of this inflation is spread evenly among the nation's 213 million citizens, that cruel inflation for just a four-month period would constitute imposition of a \$13 tax on every man, woman and child in America.

If the hospital cost containment program were in effect during the next four months, it would save about \$1 billion. And about \$370 million of that \$1 billion would represent savings to Federal taxpayers under Medicare and Medicaid alone.

That four-month, \$370 million in savings is more than twice as much as we propose to spend annually on the proposed Child Health Assessment Program (CHAP), twelve times more than our annual spending for research on drug abuse and fifteen times more than we will spend on the rural clinic bill recently passed by this Subcommittee.

Our nation's economy, our health care system, and, most importantly, our citizens simply cannot afford this mindless, inexorable spiraling of health expenditures that impoverish other needed health care programs and send the costs of medical care out of sight.

THE EVIDENCE OF HOSPITAL WASTE CONTINUES TO MOUNT

When I last testified before you on this issue, I identified for the committee over \$5 billion in annual savings that could be achieved in hospitals without reducing the quality of patient care. Since that time a number of investigations have revealed even more areas where savings have or could be achieved.

A recent Blue Cross and Blue Shield study in Michigan showed that a large number of patients are still admitted to hospitals on Friday and Saturday. These Friday and Saturday admissions have an average length of stay 1.7 days longer than admissions during the rest of the week. The study notes that "the sheer number of patients and hospitals . . . suggest that many patients hospitalized on Friday and Saturday receive only custodial care . . . and not medical care on these days." If we eliminated these unnecessary hospital days nationwide, we project \$2 billion savings in fiscal year 1977.

The Food and Drug Administration has estimated that up to 50 percent of hospital diagnostic x-ray exposure is unnecessary—up to 30 percent of the x-rays taken are merely to protect the physician against malpractice suits. For the x-ray units sold in 1976 alone, the savings is estimated at \$70 million, if these units were used in an appropriate fashion.

We also continue to hear of the questionable medical efficacy of certain medical procedures. For example, a preliminary study reported in the *New England Journal of Medicine* suggests that, for many patients suffering from chronic stable angina, coronary bypass surgery may be no more effective in prolonging life than conventional drug therapy. The cost of bypass operations is estimated to be \$1 billion in 1977. If the results of this preliminary study are confirmed, hundreds of millions of dollars could be saved through less frequent use of this expensive surgery.

In Atlanta, a group of neurologists installed a C.T. ("CAT") scanner across the street from a hospital which they knew would install a similar scanner, with planning agency approval, only three months later. In that metropolitan area of only 1.5 million persons, there are already 17 CAT scanners. By comparison, Connecticut's certificate of need program has determined that eight scanners can meet the needs of the State's entire population of 3.2 million persons. Presently, only six scanners are in place in that State. This contrast dramatizes the need for tighter controls on reimbursement and capital investment and stronger area-wide planning.

At the same time, we have seen a recent study of 120 hospitals that shows that their radiology and pathology specialists average \$100,000 per year or more. Those who are paid a percentage of charges billed by the hospital earn more than twice those receiving salaries. This practice, as the Subcommittee has demonstrated, must be changed.

In Orange County, California, hospitals are running at an average occupancy rate of 54 percent. This means, according to the executive director of the Orange County Planning Council, that "two out of four hospital beds are unneeded." He stated further: "We have more inpatient resources in Orange County than we expect to need through the year 2025." Yet in the country there are still millions of dollars committed to building new absolutely unneeded facilities in the future.

These examples—and I submitted other items of waste on a "fat list" that was appended to my June 7th statement—underscore the ineffectiveness of voluntary restraints so long requested by the hospitals. But the items from Atlanta and Orange County illustrate another aspect of the problem: they are symptomatic of the hospitals' tendency to play "keep up with Jones's," using precious taxpayer dollars on wholly unnecessary equipment and facilities in order to compete with each other.

Mr. Chairman, isn't it time that hospital administrators and comptrollers throughout the nation were forced to face the challenge of producing immediate savings by trimming unnecessary spending? They must realize that, without some restraint on spending, the blank check they have had for a decade will someday bounce.

Hospital profligacy unchecked will bankrupt the health care system and diminish health care for all Americans. The hospital industry must learn—just as all citizens and all other government agencies have learned—to live within reasonable limits. We must stop the rampaging inflation of hospital costs.

The Hospital Cost Containment Act

I must repeat the position I expressed in my earlier testimony. The only way reforms can be achieved is through a process that begins with a transitional hospital cost containment program such as the one the Administration has proposed.

Under present estimates, the savings resulting from implementation of the Hospital Cost Containment Act—assuming immediate passage—would be approximately \$2 billion in FY 1978, including \$715 million in Medicare and Federal

Medicaid and \$1 billion in private funds. By FY 1981, net savings would be \$12.3 billion, more than six times the savings in FY 1978. This would include \$1.9 billion in Medicare and Federal Medicaid and \$6.2 billion in private funds.

Included in the proposal are two basic grounds for exceptions—major changes in patient loads (more than a 15 percent increase in admissions) and major changes in new capital facilities or equipment. In both cases the state health planning and development agency would have to approve exceptions. The hospital would also have to demonstrate that its current assets are less than twice its current liabilities, in order to justify additional revenue to finance major changes in the hospital's plant and equipment.

We also permit an optional adjustment for increases in the wages of non-supervisory employees. Wages have not been the driving force in hospital cost increases. In recent years, yearly increases in wages and non-supervisory hospital workers have averaged 7.2 percent. Even assuming that these wages should increase at a rate of 9.5 percent, the allowable revenue limit would be increased by less than a percentage point. This provision is important to protect low-wage hospital workers from any adverse impact of cost constraints.

Title II of our proposal would establish a \$2.5 billion national limit on new capital expenditures by acute-care hospitals currently subject to Federal and State certificate of need laws. This should be sufficient to support needed maintenance or conversion activities as opposed to construction of unneeded new beds. It also would permit a gradual expansion of hospital equipment. These limits would initially be allocated to the states on a population basis.

The program would build on existing Federal Health Planning Authority by limiting net increases in hospital beds in areas already well in excess of hospital bed needs—those with more than four beds per thousand population or an average occupancy rate less than 80 percent.

The bill includes provisions to assure that hospitals will continue to carry their charity patient load and will disclose the information necessary to allow for informed choices by consumers and other interested parties.

We also recognize the importance of efforts in certain states that have undertaken their own cost containment initiatives. Hospitals in states that have strict cost containment programs and that meet other specified conditions may be excluded from coverage under the Federal program.

Mr. Chairman, you initially expressed some reservation about our program's differential impact on efficient and inefficient hospitals.

The Administration's original proposal did build a number of rewards for hospitals which choose to become more efficient:

Hospitals that close unnecessary facilities or eliminate duplicative equipment would have the allowable revenues for these services retained in the cost base for that particular year (if the HSA approved discontinuance of these services). Thus, the hospital would be permitted a greater than 9 percent increase on remaining services.

As hospitals urge their medical staffs to eliminate unnecessary tests, admissions, and shorten their length of stay, the allowable revenue per unit of service would increase.

Communities that take steps to reorient current excess facilities and services are allowed to reallocate at least part of these savings in order to meet current needs more effectively.

While we have included a number of positive incentives in our cost containment proposal as originally drafted, I have been struck that all the committees in both houses of Congress strongly want to have as many provisions as possible that reward efficient hospitals and penalize inefficient ones.

The efforts of this committee are especially important in this regard.

Other committees have also been exploring methods of rewarding hospitals directly for efficient performance. Chairman Rogers has suggested incentive payments to hospitals that experience cost increases below the allowable limit. Chairman Rostenkowski has suggested establishing a variable rate of increase for the revenue limit, based on the relative performance of a hospital compared to its peers.

Chairman Rostenkowski's proposal is consistent with the reforms being proposed by this committee, but it would be equitable only if applied to an adequate system of classifying hospitals according to relevant cost-based characteristics. As noted in June, we unfortunately do not yet have adequate data or methodologies for developing such a system for total costs.

Nonetheless, we are committed to working with you and the other health subcommittees to assure the earliest possible implementation of proposals designed to use positive incentives to achieve cost restraints.

In this respect, I would like to comment briefly on the hospital cost containment bill approved in the Senate Human Resources Committee. The actions taken by that Committee are generally consistent with our objectives and we are grateful for its thoughtful and speedy work. Nonetheless, several specific provisions cause us concern.

Title I of our bill was designed as a transitional program, to be replaced as soon as possible by a system of permanent reforms. That is why we selected the particular spending limit formula, exceptions process, pass-through mechanism, and State waiver provisions set out in our bill. We must limit additional implementation, reporting, and policy development activities related to the transitional program over the next 12-24 months if we are to devote our full attention to the development of a system of truly permanent reforms, such as those proposed by this Subcommittee. By requiring the Secretary to develop a more sophisticated index to replace the current limit formula after one year, and by suggesting a broadening of the exceptions process, Title I of the Human Resources bill, therefore, lends more complexity to the transitional system than we think is appropriate. We are also concerned by the expansion of State programs in Title I of the Human Resources bill because we fear precipitous implementation of untried methods would undermine effective cost containment efforts.

By contrast, Title II of our bill is intended to be part of permanent reforms in the planning and capital regulation process. Therefore, while we recognize the need over time to modify some of the specific indices, occupancy standards, and bed ceiling standards, these changes are all intended to be achieved in the context of our proposed Title II.

The Human Resources bill provides for a moratorium on capital expenditures; however, the exceptions permitted are potentially so broad that approvals could conceivably exceed our proposed \$2.5 billion capital expenditure ceiling. One should not underestimate the ingenuity of individual institutions to design capital projects ostensibly to meet the requirements of building codes or voluntary accreditation standards. Also, it will be very difficult for planning agencies to resist pressures to replace services if there is no maximum restraint on capital expenditure approvals.

I would also like to comment briefly on some of the specific provisions of this Subcommittee's recent modifications to S. 1470. I would note at the outset, however, that my comments must be general because we have not been given a copy of the redrafted bill.

I strongly support the changes contemplated in Section 2 of S. 1470 that moves from a system limited to routine costs to one that covers most other costs as well, from a system limited to Medicare and Medicaid reimbursement to one that includes all third-party reimbursement, and from a system that would have its first effects starting in FY 1981 to one that would take effect earlier. However, I am still not sure that the proposal as it now stands would result in any significant savings.

First, one basic difficulty—which I mentioned in June and which continues to pose problems—is that the reporting systems now in place and used in administering retrospective cost reimbursement do not, in and of themselves, provide an adequate base upon which to establish the system of prospective payment limits envisioned in the Subcommittee's reforms. Efforts to build long-term reform on this inadequate base or to revise the reporting structure precipitously, without adequate lead time for hospitals and administrative agencies, will invite confusion rather than institute real control. For example, the wage adjustment mechanism used in calculating the limits on ancillary service costs would take considerable time to implement since the necessary data are not now available. The market basket study needed to determine hospital ancillary service costs will be a time consuming and complex project. Finally, classification systems as proposed are a long-term method. Combined with the need for data that are just not available at present we would be seriously undermining any cost containment potential by seeking to implement the Subcommittee's proposal in place of our program.

Second, I am also concerned that the twin limits on routine costs and on ancillary costs—the first, a limit on the level of routine per diem costs, the sec-

ond, a limit on increase in per admission ancillary costs—will invite hospitals to increase days or stays or both for no other reason than to maximize revenues. Because of administrative complexities that result from imposing separate limits on ancillary and routine costs, it may be difficult to identify such abuses. Under the Administration's proposal, such abuses would be more easily identified because a combined percentage increase on both routine and ancillary revenues is established. At a minimum, however, if the Subcommittee wishes to retain separate routine and ancillary cost ceilings, there ought to be a percentage increase limit on routine as well as ancillary costs.

Third, the proposed exclusion of malpractice insurance premiums, energy costs, capital related costs, costs of education and training programs, costs of interns, residents and non-administrative physicians' medical services, and certain costs unique to proprietary institutions adds to the administrative complexity and promises questionable gains. For example, recent evidence indicates a significant lessening of pressures for malpractice insurance premium increases. The 43 institutions in the Maryland Hospital Association group insurance program have not had a malpractice insurance rate increase since mid-1976. The 440 hospitals in the California Hospital Association program will face a near zero increase next month, after increases of 15 percent and 100 percent in the two previous years.

Fourth, the proposed absence of any capital expenditure controls, such as those proposed in Title II of the Administration's bill, will permit continued capital investment of billions of dollars each year and permit continuation of the unacceptable 15 percent annual inflation rate of capital expenditures experienced in recent years. In addition, the pass through of all operating expenses associated with approved capital projects could virtually negate any positive effects of constraints on payment for routine and ancillary costs.

Finally, I recommend that the committee must place additional emphasis on the provisions of our proposal that limit increases in operating expenses due to "approved" capital spending during the transitional program. We have, as I said earlier, included exceptions for new capital spending and associated operating costs. But we believe that hospitals should not ask their patients to bear these added costs during the program as long as the hospitals have huge accumulated reserves which include the \$1.2 billion in profits earned by hospitals in 1976. I fear that the capital spending pass-through being contemplated by the Subcommittee may provide an enormous loophole. We must simultaneously enact strict limits on new capital spending. Until such provisions are in effect, the long-run inflationary pressures caused by duplicative and unnecessary technology will continue.

Mr. Chairman, let me also briefly indicate certain provisions of S. 1470 that we think are outstanding examples of the far-sighted efforts of your Subcommittee.

For example, the Subcommittee is to be applauded for the provisions dealing with the problem of overcapitalization in the hospital industry. The Subcommittee's concern with elimination of unnecessary hospital beds, as reflected in Section 3 of S. 1470, and with strengthening sanctions against institutions which provide services with unapproved capital facilities or equipment, as reflected in Section 4, is shared by the Administration.

The Subcommittee has also focused attention on the need for alternatives to hospitalization such as skilled nursing facilities. Section 20 of S. 1470 allows for small rural hospitals to receive reimbursement for furnishing services which, if provided by a skilled nursing facility, would constitute post-hospital extended care services for purposes of Medicare and Medicaid reimbursement.

Finally, the special role played by this Subcommittee in reforming the method of paying for the services of hospital based physicians such as radiologists, pathologists and anesthesiologists is worthy of note. Your penetrating insight into the nature of the abuses in this particular area, as well as their solution, should serve as a model for all others who seek to improve the functioning of our medical care system. We support you fully in this regard.

In summary, Mr. Chairman, let me again recall your own words of May 5, 1977, when you introduced S. 1470, the proposed Medicare-Medicaid Administrative and Reimbursement Act. You stated that S. 1470 "represents a long-term basic structural answer to the problem of rising hospital costs, whereas the Administration is calling for a short-term interim cap on revenues to be in place only until a long-term solution can be established." We recognize that our proposal is only a short-term measure, but it is no less necessary for being short-term. Furthermore, it will serve the critical function of curbing the intolerable rise in hospital costs

simply, quickly, and effectively. We appreciate the efforts you have made, as well as those of the Senate Human Resources Committee, to increase the sophistication of our initial efforts in this area. However, I continue to believe that our initial proposal is the best immediate alternative, under present circumstances, to the continued escalation of unnecessary hospital costs. I urge the Committee to report favorably on our proposal for it is the only alternative that can promise quick relief from the oppressive, destructive inflation in hospital costs. But more important, it is the only proposal that will begin immediately to set the stage for the kinds of longer term solutions we all agree are necessary.

Thank you.

APPENDIX TO STATEMENT OF JOSEPH A. CALIFANO, JR., BEFORE THE SUBCOMMITTEE ON HEALTH OF THE SENATE FINANCE COMMITTEE, WEDNESDAY, OCTOBER 12, 1977

The Committee has also requested that we comment on H.R. 8423, a bill to make improvements in the Medicare End-Stage Renal Disease (ESRD) program. The Department supports this bill. We have worked closely on the measure with the staff of your committee and the Committee on Ways and Means of the House of Representatives. We believe it goes a long way towards solving some of the more pressing problems faced by this innovative program.

The ESRD program was originally enacted as a floor amendment to the Social Security Amendments of 1972. It has been a challenge to all of us. While there have been and continue to be problems in the administration and evaluation of the ESRD program, we have gained valuable experience that will help us as we consider options for a National Health Insurance proposal. For the ESRD program is, in fact, a miniature National Health Insurance program for those with a specific life-threatening illness.

I know that members of this Subcommittee recognize the major problem—the need to control the costs of this program. We now pay over a half a billion dollars a year for the health care services required by 34,000 eligible beneficiaries. We hope this bill will help to control these costs by encouraging self-care dialysis and kidney transplantation and by clarifying reimbursement procedures. I should point out, however, that the costs of this program have escalated primarily because of the increasing number of patients eligible for care and the general inflation in health care costs that affects all health insurance programs.

Let me briefly highlight several aspects of H.R. 8423 that we feel will be particularly helpful. There are several provisions that would encourage self-care dialysis:

- Waive the 3 month waiting period for individuals who participate in self-care training program,

- Provide coverage for all supplies, including disposable supplies, needed to dialyze at home,

- Authorize payment to approved renal disease providers and facilities for the full reasonable cost of the purchase, installation, maintenance and refurbishing of dialysis machines for the exclusive use of beneficiaries dialyzing at home, and

- Authorize payment to approved facilities on the basis of target reimbursement rate for all necessary home dialysis medical supplies, equipment and support services.

While we recognize that many patients are not suitable candidates for this mode of treatment, we want to encourage those who are so that they may live the fullest life possible.

We also strongly endorse the section of the bill that would extend Medicare coverage for patients who undergo a kidney transplant to 36 months after transplantation. The current 12 month termination period has proved inadequate for the needs of these patients. Furthermore, it is comforting for these patients to know that they will have immediate resumption of their Medicare coverage if a transplant fails.

Finally, we appreciate the detailed guidance now provided in both the bill and the Committee report language concerning reimbursement procedures both for physicians and facilities. We believe there was a need to clarify the intent of the original floor amendment in this area both for the Department as the program administrator and for those who actually provide vitally needed services to ESRD beneficiaries.

Senator TALMADGE. Our next witness is our distinguished colleague, Hon. Richard S. Schweiker, a U.S. Senator from Pennsylvania.

Senator Schweiker, we are delighted to have you appear before our committee, sir. You may, if you like, insert your full statement into the record and summarize it in any manner that you like.

**STATEMENT OF HON. RICHARD S. SCHWEIKER, A U.S. SENATOR
FROM THE STATE OF PENNSYLVANIA**

Senator SCHWEIKER. Chairman Talmadge and Senator Dole, I appreciate this opportunity to present my views on the complex and perplexing issue of hospital cost containment to this distinguished subcommittee. As the ranking minority member of the Health Subcommittee of the Human Resources Committee, I am well aware of the difficulties of the task you face in formulating this legislation. As you know, our subcommittee and the full Human Resources Committee recently completed consideration of the President's hospital cost containment proposal, and after making substantial revisions referred it to your committee for further action. I commend your subcommittee for the very serious scrutiny it is giving these matters and look forward to working with you for a measure to limit the dramatic increases in hospital costs which is fair and workable for all concerned.

On July 18 of this year, I introduced S. 1878, emphasizing State control of hospital costs, as an alternative to the Carter administration's Federal control plan. Senator McIntyre joined me in this effort, and Senators Chafee and Laxalt also joined as cosponsors. Congressman Rogers subsequently introduced our bill in the House as H.R. 8633.

After devoting weeks to study and hearings of the administration's hospital cost containment proposal, I had come to the conclusion that the Carter plan was an overly centralized, temporary measure falling far short of what this Nation needs. I believe the emphasis our bill places on State control of hospital costs, the positive incentives it provides to hospitals to control costs, the 18-month moratorium it imposes on capital expenditures, and the decertification authority it provides health systems agencies would significantly improve our chances of success in containing hospital costs.

Under the Schweiker-McIntyre "State Cost Control Plan for Hospitals," each State would establish a hospital review commission to examine in advance the proposed budgets and rates of hospitals within the State. Through prospective budget review, the commission would approve routinely any proposed budgets and rates falling within limits it would define. However, rates and budgets exceeding those limits would be subjected to detailed examination and those found to be excessive could not be put into effect.

I believe that the States can and will meet this challenge. The political pressures for cost containment and the Federal technical and financial assistance provided them under our bill will motivate many

States to enact plans quickly. In those States which do not, Federal limits would remain in effect.

The Schweiker-McIntyre plan would allow the Secretary of Health, Education, and Welfare to exercise Federal control in a State which did establish a hospital review commission only if the commission failed to hold hospital costs at or below the Federal limits. Our legislation would also provide start-up money to the States for establishment of the commissions.

In addition, S. 1878 would offer positive incentives to hospitals to control costs. If during the year, a hospital remains within the budget approved prospectively by the commission, it could retain its achieved savings up to a certain level or use its cost savings for experiments in administrative efficiency.

S. 1878 proposes an 18-month moratorium on hospital capital expenditures. This moratorium would allow the developing health systems agencies to become more fully established and to develop the capacity to exercise the decertification authority provided to them under our plan.

Our bill would also authorize the HSA's to decertify unneeded beds and services and would establish a Federal pool to finance the costs of decertification.

Finally, S. 1878 would extend the authority of professional standards review organizations to care provided all hospital patients, not just medicare and medicaid patients, as under present law.

Members of the subcommittee will note that a number of our State-oriented proposals were incorporated into S. 1391 by the Human Resources Committee when it approved the bill on August 2.

The most significant of these is a new section (119) encouraging the States to establish their own cost containment programs which the Secretary would be required to approve if certain minimum standards were met. The bill also authorizes a \$10 million fund for startup grants to assist the States in the developing of their commissions. The States would have great flexibility in developing new—and hopefully innovative—cost containment methodologies, but they could lose their exemption from the Federal program if they did not achieve aggregate savings across the State of within 110 percent of the Federal cap. In addition to these provisions encouraging new State programs, the Human Resources Committee expanded the criteria for exempting existing State programs such as those in Connecticut, Wisconsin, and New York, under section 117 of the bill.

As we had proposed in S. 1878, the human resources bill also includes provisions for a national moratorium on capital expenditures, and it grants the HSA's authority to decertify surplus facilities and services.

While I was pleased that these sections of our cost containment bill were included, I was unable to support the final version of S. 1391 approved by the Human Resources Committee because of the mandatory wage pass-through it would impose at both the State and Federal levels. For the reasons detailed in the minority views of our commit-

tee's September report on hospital cost containment, I feel that a region-by-region approach to lingering wage inequities among hospital employees is far preferable to the blanket nationwide exemption of the human resources bill. Available statistics demonstrate that the problem is regional in nature. Thus, where the States have implemented their own cost containment programs they should retain complete discretion over how to deal with the wage inequities problem as it exists within their jurisdictions. I strongly hope that the difficulties associated with the wage pass-through can be disposed of so that I can support the measure on the Senate floor.

Finally, I am happy to note that a number of our State-oriented proposals have been added to cost containment legislation approved by the Health and Environment Subcommittee of the House Interstate and Foreign Commerce Committee.

Due to my interest in broader State exemptions for cost containment programs, I was pleased that the original version of S. 1470 and the specifications for a revised version recently distributed by the committee would allow State programs to be exempted from Federal revenue limits if they met certain requirements. As more detailed revisions of this legislation are developed, I would urge the subcommittee to consider carefully the merits of the Schweiker-McIntyre proposal.

Our approach reflects confidence that, with a little encouragement and assistance from the Federal Government, the States can achieve greater actual savings in a far more equitable manner than a uniform system administered from Washington, D.C. State programs foster successful experimentation and attune regulatory controls to widely differing health care programs across the country. State programs are more likely to be responsive to the many variations throughout the hospital industry, more administratively flexible, and more accessible to both providers and consumers of hospital care than a purely Federal program. State programs will also facilitate the coordination of cost control efforts with local health planning and quality review programs.

Specifically, I would single out the following elements as particularly important to the success of a State-oriented alternative:

One, the minimum requirements States would have to meet to obtain an exemption from the Federal limits should be clear and fully ascertainable before the States apply for exemptions. In other words, the authority of HEW to alter conditions for approval and thus frustrate the development of State programs should be extremely limited. If certain prerequisites are met, the Secretary should be required to grant an exemption.

Two, the minimum criteria for obtaining an exemption should permit the States as much program flexibility as possible in order to foster experimentation and encourage localized cost containment techniques.

Three, a generous Federal fund for startup grants should be established along the lines of S. 1878 and the Human Resources bill. The investment would quickly be recovered in medicare and medicaid savings.

Four, in order to assure that the national cost containment objectives are achieved, the States should be required to meet quantitative cost-savings goals, calculated on an aggregate, statewide basis. While my original proposal would require them to meet the same savings goals as the Federal program, a slight additional margin in the early years of the State programs may be necessary to give them the incentives and time to become fully functional.

Again, let me express my appreciation to the subcommittee for the opportunity to appear before you today in order to advocate our State-oriented approach.

Senator TALMADGE. Senator, you heard Secretary Califano's comment on State hospital cost control programs. Do you wish to respond?

Senator SCHWEIKER. Yes; Mr. Chairman.

First of all, I think it is important to note—he seemed to omit this fact—that under our proposal, if the States institute a program and do not meet the Federal standard in 1 year, they simply lose their right to control their own destinies in the cost containment area. I do not know what stronger incentive you could have than that. That is one of the very important benefits of our alternative.

Another answer is that seven States have already instituted their own cost containment programs. I happen to believe all States can do it if they are motivated to and if we give them an incentive to do so. I think that is exactly what our bill would do.

Finally, I think Secretary Califano is overly confident about the administrative capacities of HEW. The committee already pointed this out in noting the way they have administered student loan repayments.

I think we overestimate how able our bureaucracy is to oversee every hospital in this country from Washington.

Senator TALMADGE. What was the average cost increase in the seven States that have their own control programs?

Senator SCHWEIKER. We have the Library of Congress working on statistics to measure the success of State programs.

Senator TALMADGE. As soon as you get that information, will you submit it in detail? Each State over the last several years, or as long as they have had their cost control program.

Senator SCHWEIKER. I certainly will, Mr. Chairman. These data have not been readily available. We do have the Library of Congress working on it, however.

Senator TALMADGE. I think it would be important for the record to see how well it has been working in each State.

[The following was subsequently supplied for the record:]

TOTAL EXPENSE, ANNUAL PERCENTAGE CHANGE BY STATE, 1970-75

[In percent]

By region States	Total expense—						
	1970 ¹	1971 ¹	1972 ¹	1973 ²	1974 ²	1975 ²	1976 ²
West North Central:							
Minnesota.....	17.97	10.67	11.07	8.16	13.84	16.81	8.84
Iowa.....	16.89	9.98	10.42	10.09	14.41	18.58	18.79
Missouri.....	15.39	11.84	14.29	12.87	18.06	20.28	17.33
North Dakota.....	2.23	22.42	6.80	8.90	11.51	23.69	23.50
South Dakota.....	24.23	8.16	7.89	6.77	15.60	20.13	17.77
Nebraska.....	11.19	14.69	12.15	8.95	14.91	18.61	16.38
Kansas.....	16.23	14.16	8.08	12.95	12.53	20.04	14.99
West South Central:							
Arkansas.....	21.57	12.16	12.75	12.75	18.70	18.10	22.67
Louisiana.....	20.21	13.81	26.59	— .84	14.37	25.60	13.72
Oklahoma.....	18.48	15.84	13.47	11.41	16.88	22.20	17.11
Texas.....	20.70	12.57	13.62	13.68	15.05	19.34	20.28
Mountain:							
Montana.....	8.33	12.26	10.43	6.65	10.24	17.80	16.85
Idaho.....	18.50	16.54	13.69	9.89	13.41	19.32	15.37
Wyoming.....	11.79	11.54	8.21	10.15	13.10	19.36	19.25
Colorado.....	12.26	15.51	13.43	9.06	14.38	22.72	20.04
New Mexico.....	15.40	15.14	18.51	10.23	9.94	22.23	28.54
Arizona.....	23.33	16.79	27.66	15.26	15.80	18.05	14.27
Utah.....	22.99	9.31	12.67	12.70	15.52	18.37	13.48
Nevada.....	14.61	15.14	14.71	29.18	19.24	19.14	17.35
Pacific:							
Washington ³	15.57	10.44	11.93	12.94	10.99	21.67	16.69
Oregon.....	15.20	14.49	12.20	13.67	17.68	16.49	22.07
California.....	20.15	11.37	16.86	10.81	17.86	18.63	14.46
Alaska.....	16.26	21.54	24.94	14.74	16.97	36.62	26.27
Hawaii.....	31.00	— 4.54	12.08	9.10	9.07	16.51	20.44
New England:							
Maine.....	14.45	19.79	7.65	13.97	24.30	22.03	13.19
New Hampshire.....	18.44	11.06	15.71	10.08	14.86	19.70	13.96
Vermont.....	14.65	8.43	9.07	10.72	13.28	14.26	13.68
Massachusetts ³	17.08	16.32	12.48	11.41	14.25	17.32	13.35
Rhode Island ³	11.72	15.12	9.93	10.61	12.52	20.51	9.76
Connecticut ³	18.40	16.75	10.13	11.46	10.15	17.58	13.41
Middle Atlantic:							
New York ³	17.22	14.67	15.02	10.00	11.42	19.89	3.07
New Jersey ³	20.09	17.75	12.10	15.53	16.98	17.97	13.87
Pennsylvania.....	12.74	18.99	11.35	8.88	13.78	17.52	16.01
South Atlantic:							
Delaware.....	19.36	10.96	13.56	9.60	10.23	28.75	13.41
Maryland ³	19.39	22.34	12.42	13.43	11.26	19.83	11.87
District of Columbia.....	20.95	17.86	5.93	8.01	7.72	18.04	19.24
Virginia.....	20.75	16.50	13.93	14.27	12.43	20.82	17.25
West Virginia.....	15.89	4.22	17.79	17.71	13.57	19.77	17.43
North Carolina.....	18.84	11.91	14.66	12.05	18.20	17.03	14.68
South Carolina.....	14.25	13.37	13.80	17.00	18.57	20.83	16.00
Georgia.....	20.47	21.53	18.53	13.80	19.91	18.66	16.32
Florida.....	24.21	17.33	15.45	15.02	24.61	27.63	14.73
East North Central:							
Ohio.....	19.37	12.54	15.01	10.84	15.24	20.31	15.28
Indiana.....	16.47	17.00	12.10	11.43	14.02	19.08	16.83
Illinois.....	17.69	15.71	13.75	12.03	14.08	18.17	15.62
Michigan.....	21.91	16.05	19.47	11.71	16.42	20.29	14.54
Wisconsin ³	16.87	11.22	12.68	11.40	13.06	16.82	17.64
East South Central:							
Kentucky.....	14.50	14.26	12.55	15.71	11.60	18.12	17.57
Tennessee.....	15.45	14.46	13.94	15.23	11.75	18.13	17.19
Alabama.....	14.73	17.69	12.25	13.39	16.98	17.10	18.17
Mississippi.....	29.23	15.77	11.09	12.20	17.90	19.98	17.58

¹ Figures are simply the percentage increases.² Percentages used actual total expense figures not average percentage increase.³ States which now have some form of cost control program.

Source: Data submitted by American Hospital Association.

Senator TALMADGE. What are your views on the issue of mandatory wage passthroughs for nonsupervisory hospital employees?

Senator SCHWEIKER. I think, Mr. Chairman, that on this issue both the administration's original proposal and the one that came out of the Human Resources Committee are completely counterproductive.

We said we wanted to control hospital costs, and we ended up saying we wanted to control only some hospital costs.

In essence we are solving one problem and creating another problem.

I think the figures are very interesting on this because, over the last 10 years, the average nonsupervisory wage increase has been 8.7 percent in the hospital area. Yet, for all private nonagricultural workers outside the hospital, it was 5.8 percent. They have had about 10 years playing exceedingly fast catchup ball and I do not buy the argument that hospital workers as a whole are all way behind.

Also, the increase in the cost of per day is to some extent attributable to increases in wages. If you put a cap on prices, in essence, but keep the lid off wages, you create further problems with the bill that is supposed to contain costs.

I do not know how we, in good conscience, can call a bill a cost containment bill but exclude wages. In fact, this bill, in its present form, would encourage every bargaining unit in the country to ask for as much as they could get. And what recourse does the negotiator have but to accede.

I cannot imagine a worse provision. This is what finally compelled me to oppose the present bill in the Human Resources Committee as much as I thought it had been improved with the addition of section 119, which was my proposal. I think it would really be a sad mistake if we passed a bill containing a wage passthrough.

Also, I think it is important to note further inequity in this bill in its present form. Seven States do not have a mandatory wage passthrough imposed on them. These seven States are given preferred treatment. The committee grandfathered them in, but the other 43 States have to pass through wages, no matter what.

What is fair for one State should be fair for another. If it is good for 7 States, it ought to be good for 50 States. How we explain giving an exemption from the passthrough to 7 States and not to the other 43, I do not know.

Senator TALMADGE. The Senate just passed a bill increasing the minimum wage by 25 percent over a 3-year period. That would be a mandatory passthrough right there, would it not?

Senator SCHWEIKER. That would be a mandatory passthrough if they are at the minimum wage rate. Frankly, with an increase of 8.7 percent per year over the past 10 years, my guess is that not all that many of these hospital workers now are at the mandatory wage level. Even if there is no mandatory wage passthrough, you have the option of increasing wages at least 9 percent a year, and probably more than that, since wages only comprise 36 percent of the total hospital budget. I cannot believe that the 9 percent cap does not allow sufficient latitude. In fact, if you look at the last 10 years, the annual rate increase is 8.7 percent.

Senator TALMADGE. I understand the administration bill and the problem pointed out by Human Resources as a 9-percent passthrough the first year and then a very complicated formula for subsequent years, so it could be less than 9 percent subsequently, or possibly it could be more.

Senator SCHWEIKER. That is correct.

Senator TALMADGE. Senator Dole?

Senator DOLE. I think Secretary Califano indicated one objection would be that it would take so long for the States to get your plan operational. Do you have any estimates? Maybe you could not estimate, but how long do you think it might be before we get your plan underway if we adopted it?

Senator SCHWEIKER. One of the reasons that our bill included an 18-month moratorium on significant capital expenditures was to enhance its impact in the short run. Because of the legislative action necessary at the State level in setting up the commissions, we put in the 18-month moratorium to provide for cost containment while the States get organized in this area.

While we do not have any statistically based time estimates on it, we are guessing, based on consultations with State representatives, that it would be between 1 and 2 years.

Senator DOLE. How would you handle the low-paid worker? If some are paid over the average, would you try to regionalize, localize rather than the automatic passthrough? How do you address the situation where somebody is underpaid, that is some nonsupervisory personnel?

Senator SCHWEIKER. Senator Javits had an amendment, that unfortunately did not carry in our committee, that makes some sense. It would have permitted a passthrough only if it could be shown that the hospital workers in the area were significantly below their non-hospital peers. That was a very reasonable approach. Unfortunately, the amendment was defeated on a tie vote in committee.

If there is going to be some passthrough—and I happen to think, frankly, that the 9-percent cap allows plenty of latitude—I think that is the way to do it.

Senator DOLE. That is essentially what we have in our proposal. In other words, you would accept that provision?

Senator SCHWEIKER. Yes.

Senator DOLE. I do not have any further questions. I think that your approach has great merit. I cannot understand any real objectives. You ask the States to participate. Apparently it has been demonstrated that they can participate, they can be efficient, can be effective.

I understand—I do not know what the next witness may say—but the American Hospital Association apparently views your proposal in some favor.

Senator SCHWEIKER. Senator Dole, I appreciate your comments. Let me just add, in closing, that this is indeed an opportunity to give the States a role to play that fits into a national policy. At the same time, we provide that if they do not perform, the Federal program will replace theirs.

That, to me, is just about the best of all possible worlds. I would hope that the committee then would seriously consider this kind of an approach. After all, considering the bureaucracy and the redtape, I would shudder to think what running all of the hospitals from Washington would mean for this country. Thank you.

Senator TALMADGE. Thank you, Senator Schweiker, for an excellent statement.

Our next and final witness for today is Mr. John Alexander McMahon, president, American Hospital Association.

Mr. McMahon, we are delighted to have you back with us again. If you so desire, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. McMAHON. Thank you, Mr. Chairman, and good morning. Good morning, Senator Dole.

I am Alex McMahon, president of the American Hospital Association. With me is Leo J. Gehrig, M.D., our senior vice president.

As you know, the American Hospital Association represents most of the Nation's hospitals. We would like this morning to have the full statement included in the record and I will summarize, Mr. Chairman, commenting on S. 1391, the Carter administration proposal and the revised version reported by the Human Resources Committee, then your own bill and its alternatives.

Mr. Chairman, we explained our opposition to S. 1391 in testimony on June 8. At that time, we explained the reasons for hospital cost increases and obviously we have a vastly different point of view than that voiced by the Secretary.

Inflation in the economy as a whole and the particular inflation in the hospital market's basket of goods and services, which is rising faster than the Consumer Price Index, accounts for 10 percent of last year's 15-percent rise in hospital costs. The other 5 percent is attributable to the increased intensity of services and improvement in services that goes on at different rates in different hospitals.

Moreover, we have substantial costs for complying with government regulations and finally, of course, as we mentioned on June 8, there is the demand for more services from patients that stems from broad coverage under governmental and private insurance programs.

To reduce this rate of increase must involve not only the hospitals and doctors, but the hospital insurers, the employers, the consumers, who have some responsibility for taking care of their own health needs.

Hospitals are concerned, Mr. Chairman, as we noted on June 8 and are working to contain the costs. An example here or there of an inappropriate activity ought not to blind us to the fact that hospitals are cooperating with planning agencies. They are developing utilization, review and medical audit programs to be sure that every admission is necessary and the length of stay is appropriate.

We have supported the antifraud and abuse provisions of legislation that you have sponsored, and we pointed out that individual hospital efforts to contain costs can be quantified in the \$1 billion to \$2 billion-a-year range.

We appreciate your concern and the concerned evidence this morning by questions, both from you and from Senator Dole, about simplistic solutions. We have said before, the administration's proposal is inequitable and wrong in concept and will be impossible to administer.

We have major problems with the limited delegation to States with rate review programs; with the percentage cap which would soon

reach 5 percent, not the 9 percent that is continually used; with the limited exceptions solely for the sake of simplifying administration; and with its class of purchaser concept which has many inequities, as your questions reveal. It would impair improvement in the hospital services and would, in many hospitals, even require a reduction in services, as a survey of ours has recently noted.

We listened to the Secretary's argument for urgency and we appreciate the committee's concern and their following up with questions about the proposals' impact on services. We object to his argument against your exclusion of certain costs from the caps, because the administration's own priorities for manpower development, for example, and even for the improvement of facilities to provide greater access to the handicapped are part of the problem of the increase in hospital costs.

We object to his argument for urgent action because of the complicated programs underway now to control costs. We reject the suggestions of the lack of cost concern by the hospitals, because it does not square with the efforts now going on. We object to his examples, such as Michigan, because it ignores the differences between that and the proposals brought by the administration.

Mr. Chairman, in respect to S. 1391 as reported by the Senate Human Resources Committee, this version does contain improvements over the original proposal, particularly in the broader delegation to States with effective programs and the provisions that would encourage the development of additional State programs, and finally with its floor on increases to protect hospital services.

Particularly, we like the use of a cumulative cap as distinguished from the original proposal, but the Senate Human Resources version does contain still—they have kept the original Carter proposal—a limited exception to class of purchaser application and other provisions.

We oppose this version because it, too, is inflexible, inequitable, and restricts the hospital's ability to serve patients.

Mr. Chairman, I come to your proposal and to the proposed new specifications to extend it to all payors and all hospital services. As we noted on page 9 of the full statement, your proposal recognizes the unique characteristics of the health care delivery system and it constructively addresses a number of critical issues.

I would like to make three major points.

First, we thoroughly approve of the State option. We noted our approval on pages 9 and 10 of the statement. We would like to see it broadened to include effective voluntary programs. If I understand the situation and the reference to Michigan that the Secretary made, that is one State that operates in that fashion.

We agree with the ceiling on increases because that is one way to assure effectiveness, but we would also see a floor on increases as well, as Senator Schweiker noted.

We would like to see States encouraged to develop effective and flexible programs, and therefore we agree with the point that Senator Schweiker made on that.

In sum, Mr. Chairman, we believe that State programs can provide flexibility, as well as experimental approaches, to cost containment

and can be surrounded with adequate safeguards to assure their effectiveness.

Second, we noted on pages 11 and 12 of our statement our reaction to the new approach to revenue limits for routine services. We believe this approach will be assisted by the uniform reporting requirements in legislation now completing its course.

We appreciate, Mr. Chairman, your attention to our concern for the requirements for uniform accounting. We think we can develop the adequate data base with uniform reporting. We offer our help in developing the necessary data base, because with the proposed speedup in implementation of your reimbursement reform program, help in developing an adequate data base will be needed, and we think it can be developed.

Finally, we appreciate the exclusion of costs that are beyond the hospital's control, like malpractice insurance, energy, and the other matters. I agree, Mr. Chairman, that the setting up and the implementation of such a program will require a flexible process. We are studying the implications of a cost-based approach to revenue limitations on routine services, to be sure that it will achieve the results we are seeking—the encouragement of sound cost containment activities by all hospitals.

We want to be sure that there is adequate protection, too, against regulations that might sacrifice necessary services merely to achieve budgetary objectives. We appreciate your concern on that point.

Third and finally, Mr. Chairman, we have set forth our reactions to the limitations on the ancillary services on pages 12 to 14. Certainly it will help to develop a long-term classification approach if it proves feasible, but we appreciate your efforts for a better approach to revenue per admission controls than the approach urged by the administration. We see that your formula considers hospital costs instead of costs in the rest of the economy that do not move at the same kind of rate.

We see in your bill a better exception process that can respond to the individual institutions' problems, and we see also a recognition of the impact on cost of new services and changes in patient mix and other changes.

In conclusion, Mr. Chairman, we recognize that your approach is a complex one, but so is the problem of hospital costs. We stand ready to help in working out the details. We may find a need for modification, perhaps an exemption, for small hospitals, but we appreciate, first and foremost, your understanding of our problems and your desire to reach sound solutions that will enable hospitals to continue to serve patients.

Thank you.

Senator TALMADGE. Thank you very much, Mr. McMahon. We appreciate very much the cooperation of you and your association, working with our committee in trying to perfect legislation.

I know that no one likes to be regulated, but you are going to be regulated and we hope it will be in a manner that the hospitals can live with.

Does your association believe that there are a substantial number of hospitals incurring excessive costs?

Mr. McMAHON. No, sir, we do not, but on the other hand, I would not say for a minute with 6,000 hospitals providing services for patients

that there are not some inadvertent and perhaps some advertent, inappropriate instances, but those few ought not to be used, Mr. Chairman, to denigrate an industry that has, over the years, proven its ability to effectively, and cost-effectively, serve patients.

Senator TALMADGE. Does your association believe that there is a substantial duplication in overlap of equipment and services in many hospitals in this country?

Mr. McMAHON. Mr. Chairman, let me deal with the issue that gets the most attention: Beds. Yes, sir, we have too many beds today, but it is not because of inappropriate activities as is so often alleged.

We made assumptions in the fifty's and sixty's about increases in population, increases in hospital utilization, increases in the birth rate that have turned out to be inaccurate, but they were made in good faith at the time.

But yes, in some communities we have too many beds. We must work through the planning process to deal with those issues in a variety of ways, at the present time.

Senator TALMADGE. Do you see any substantial duplication and overlapping of equipment and services besides beds?

Mr. McMAHON. Because of the health care system, Mr. Chairman, yes, there is some of that. It grows out of the desire of hospitals and their medical staffs to provide a full range of services to patients, but with the attention that is being directed at some of this duplication we believe that hospitals are now much more ready to cooperate, as are their medical staffs, in the elimination certainly in the future of that kind of duplicatory activity and are ready now to look at some of those services now underutilized which we must cut back.

Senator TALMADGE. Does your association believe that too many hospitals are ordering and installing CAT scanners?

Mr. McMAHON. Mr. Chairman, that is a very difficult question to answer. Clearly there are pressures to install CAT scanners because of the better diagnostic techniques, noninvasive, that exists, but there is no question about the support of the hospital field to the application of certificate of need to hospitals, because this equipment would bring them under certificate of need, and we agree as well that a certificate of need ought to be carried in this kind of thing right across the entire health care system, and be applicable to all providers of care.

Senator TALMADGE. Senator Dole?

Senator DOLE. You were here when Secretary Califano testified and I think that perhaps you have touched upon some of the areas that he mentions; the evidence of hospital waste continues to mount even without the hearings 2 months ago.

Without addressing each one of those problem areas specifically, what can your association do to prevent areas of waste the Secretary referred to? Can you do anything? Do you have any powers? It is a voluntary association; I suppose that if somebody does not like it, they can quit.

How do you get people to respond to some of the abuses and to correct some of the abuses?

Mr. McMAHON. We have worked a number of ways, Senator Dole. You are exactly right; we are a voluntary association. We have tried to work by example, by setting forth in our publications and bulletins

some of the activities of individual hospitals because it is our impression that hospital people want to be cost effective. They want to serve their patients as effectively, as well as efficiently, as possible.

We publish cost containment manuals, made available to every hospital, to point out the way and the areas in which savings are possible. We have urged the development of a cost containment committee in each hospital and have given a blueprint, or a road map, by which they can proceed.

In working through our State associations and the metropolitan associations, as we call them, in many of the large cities, we have encouraged additional and localized cost containment efforts. We have encouraged the development of State rate-review programs in a number of States and the initiative for some of those programs, particularly the voluntary ones, as well as the statutory ones, have grown out of some of those activities of the State hospital associations.

Moreover, we have encouraged the development of shared services. We have provided information on mergers, on consolidations, and consortiums. We are giving specific attention now to the development and improvement of activities we have begun to call the multi-institutional approach including both regionalization and the sharing of managerial techniques that are effective cost containment efforts.

We have studied this and we see evidence after evidence of savings that we can quantify in the \$1 billion to \$2 billion range. What has happened in the past, Senator Dole, is that those savings have gone into some of the improvements in services that have come in a stream because of the activities of Government-sponsored and private research.

Now, with an improved planning process, we begin to see clear evidence that some of those savings will, in the future, rather than go into improving services be used to make reductions in the rate of increasing costs.

Senator DOLE. Are there any examples where you took direct action as an association because of what you considered or the association considered to be waste, as Secretary Califano pointed out? I do not mean these specific cases, but any cases. Have you been able to correct what was considered to be waste?

Mr. McMAHON. Not other than just through the use of peer pressure, the pointing out of areas where we have seen problems, but we have not thought that that kind of direct activity, direct control of activities, is the responsibility, or, indeed, is an appropriate activity for a voluntary association.

Senator DOLE. How about any of the individual State hospital associations?

My point is there is a lot of Federal money flowing around and nobody seems to object to taking it, but nobody wants to put the brakes on, and of course, Secretary Califano has to come forth with a proposal that not many like. But somewhere along the line, something has to give if we are going to control the costs.

Have there been any efforts on a State-by-State basis?

Mr. McMAHON. Yes, that is the reason I made reference to the inclusion of voluntary State programs, as well as mandatory State rate review. In Indiana, Wisconsin, and Michigan, which have been referred to, the State hospital associations working with some of the local payors of care, have developed screening programs to identify costs that

seem to be out of line, and working with those institutions have either come to the conclusion that there was either something unique and unusual in the development of services or the hospital's patient mix, or has said, this rate of increase is just beyond what is necessary. Their managerial and engineering specialists would then try to find out how to reduce staffing patterns, how to share services, and how to get those costs down.

We are seeing this all of the time, greater and greater interest in the State hospital associations. Texas, for example, has developed a productivity center and is now beginning to share information on how to increase hospital productivity.

Finally, there is one national effort. I overlooked—the Joint Commission on the Accreditation of Hospitals. Its efforts have been focused particularly on improved techniques for utilization review and medical audit, to make certain that the services that are provided are necessary for the care of particular patients. And it may be, as we learn more from some of the State activity, that we can add a managerial dimension to the report.

The concern has been manifested by you and the committee that the rise of hospital costs generally has gone beyond the inflation rate for the gross national product. These efforts, I am sure, if left alone and not muddled up by an inappropriate flat formula that is going to work inequities across the board, these efforts themselves will bring down the rate of increase.

Senator DOLE. According to the recent American Hospital Association report on national hospital economic activity, hospital operating margins—that is the operating income in excess of the expenses, operating expenses—reached the highest point in at least the last 5 years.

Do you think that this might be an effort by some hospitals to be building up their revenue bases in anticipation of some revenue control program, the administration's program or some other program?

Mr. McMAHON. No, sir. Let us be sure that the record is clear on this. Hospitals across the country operate at an operating loss; operating revenues are not equal to operating expenses. There is a 3-percent margin of total revenue over total expenditures because of charitable contributions to the system as well as other nonpatient revenues, revenues from parking lots, gift shops in the hospitals, et cetera.

But our figures make it clear, just as they have over a long period of time, that the system operates at an operating loss. Let me go back to the 3-percent margin again, because it is now slightly higher. It got down to 1 percent—the margin of total revenues over total expenses—it got down to slightly 1 percent during the economic stabilization program. It is now up to 3 percent.

I have absolutely no problem of justifying that 3 percent. We need a total gain. Senator, in order to provide working capital in an inflationary economy and in order to handle the collectibles and in order to build the equity base under gross borrowing which is necessary when a facility must be built or when improvements must be made.

So the need for working capital, the necessity of generating capital to provide for improvements and the question of carrying receivables all necessitate that this system operate at a small gain. We would say that a 3-percent margin overall, and much of that comes from charitable contributions, is absolutely necessary. We would take that away if

we were to eliminate charitable contributions, and we would have a system in deep financial trouble.

[The following was subsequently supplied for the record:]

HOSPITAL OPERATING MARGINS

Recent testimony by Secretary Joseph A. Califano, Jr., suggested that "... community hospitals accumulated \$1 billion in profits (or surplus revenues) that were put into hospital cash reserves in 1976. Nearly all of the reduced revenues which we are requesting could come from cutting out these surpluses for this largely nonprofit hospital industry". I would like to demonstrate why the small percentage by which hospital revenues exceed costs does not constitute excess funds but represents funds to finance necessary expenditures critical to the economic survival of the hospitals. Withdrawal of these funds, if it were to take place, would lead to bankruptcy for many hospitals, drastic curtailment of services for others, and would raise the costs of debt financing throughout the entire hospital industry, leading ultimately to increases in hospital costs.

Mr. Califano was referring to the operating margin of hospitals. This margin is the difference between total revenues and total current operating expenses expressed either in dollars or as a percent of revenues. This margin is available for such financial needs as additions to working capital, provision for long-term capital requirements, such as renovation, replacement, modernization or expansion, and in the case of for-profit institutions, return on equity after payment of taxes. Finally, some of the margin goes into a small reserve to offset deficits which occurred in previous years or may occur in future years when revenues are insufficient to cover all operating expenses. Without revenues in excess of operating expenses, at least on average over a period of years, the nonprofit hospital will be unable to keep its current assets in line with the inflationary rise in current liabilities or to pay expenses of major repairs, modernization or capital improvements. The for-profit hospital would, in addition, be unable to pay dividends to its stockholders. Eliminating the margin would wipe out the value of their investment. Although survival of each institution requires that revenues exceed current operating expenses, a major percentage of all hospitals experience deficits in operations annually because of fluctuations in revenues and expenses.

Patient revenue varies directly with the number of admissions, length of stay and other characteristics of the patient and his illness. Patient revenue usually accounts for more than 90 percent of a hospital's total revenues but is generally insufficient to cover all operating expenses. For example, during each of the past 6 years, a minimum of 3,333 community hospitals or 56.5 percent of the 5,900 community hospitals in the United States, experienced operating costs greater than patient revenues. In the 5 combined years, 1971 through 1975, more than 89 percent of all community hospitals operated at a patient revenue deficit in at least 1 year while more than 65 percent experienced expenses in excess of patient revenues in at least 3 of the 5 years. Nearly one-third, 30.8 percent, were in deficit in all 5 years. For the industry as a whole, patient revenues pay for less than 95 percent of operating costs each year. Consequently, additional sources of funds must be found to cover the patient revenue operating deficit and to provide for the capital expenditures required to stay in business.

Other sources of income not directly related to individual patients, include donations, contributions and grants as well as revenue from gift shop, bookstore, beauty shop and physician office rentals. Total revenues do not always cover expenses. An average of one-third of all community hospitals operated at a total revenue deficit in at least 1 of the past 6 years. During the 5 years of 1971 through 1975, nearly half of all community hospitals experienced a total revenue deficit in at least 2 of the 5 years. More than 28 percent reported deficits in at least 3 of the 5 years while 5 percent were in deficit in all 5 years.

In 1976, 1,700 community hospitals, or nearly one-third of the total, ended their fiscal year in deficit, with operating expenses greater than their total revenues from all sources. Nevertheless, the net difference between total revenues and total current operating expenses for the 5,900 community hospitals in the U.S. totaled \$1.225 billion and represented 2.7 percent of total revenues for the year—the same margin as the average prevailing for the decade prior to 1972. These funds were used to offset losses from previous years, especially the three years of economic controls from which many hospitals are not yet fully recovered, and were used for working and long-term capital requirements. A

relatively small share—about ten percent—of the \$1.225 billion industry operating margin went to pay dividends and income taxes owed by investor-owned hospitals. These two for-profit related expenditures, analogous to the profits within a proprietary industry, are not incurred by non-profit institutions.

Provisions for working and long-term capital needs of the institution, however, are essential uses of funds whether ownership is by governmental, non-profit or proprietary form. For example, approximately 54 percent or \$658 million of the total operating margin for the industry was accounted for in 1976 by additions to working capital which increased by 10.2 percent to \$7.097 billion compared to a 10.9 percent average annual increase since 1974. Additions to working capital are required to support day-to-day cash flows which increase along with payroll, material and other operating costs. Most of the addition is needed merely because of inflation.

The remaining balance of roughly 35 percent was available for long-term capital investment. Depending on the specific circumstances of a given hospital, long-term capital expenses may provide for replacement of existing plant and equipment, renovations and major repairs or expansion to meet changes in demand for hospital services resulting from such factors as population shifts, as well as for investment in improved technology of delivering health services. Figures are not yet available for hospital construction in 1976, but in each of the previous three years total hospital construction expenditures by community hospitals exceeded \$3 billion. Assuming 1976 experience follows a similar pattern, approximately \$400 million of funds from operations would be needed for part of the down payment and similar elements of construction expenditures. As in the past three years, the balance of construction costs would be financed by government grants and appropriations (21 percent), philanthropy (10 percent), while debt instruments would provide the major source (about 57 percent) of hospital construction funds.

Increased dependence on long-term debt as the chief source of capital financing places greater pressures on the hospital to demonstrate its ability to meet its financial obligations. Bankers and other potential purchasers of hospital debt look closely at the financial posture of institutions attempting to raise funds in the capital markets. Financial indicators such as operating margins show the ability of the hospital to meet its debt service obligations.

Declining operating margins from whatever cause would inevitably result in lower bond ratings and higher costs of borrowing, increasing dependence on borrowing for short-term working capital and the added interest costs thereof, and exclusion of some hospitals from the private capital markets altogether. In short, hospital solvency depends on the existence of revenues in excess of operating expenses.

It is clear that the hospitals' operating margin is essential for hospitals to provide their services and is not idle cash reserves that can be eliminated if revenue constraints are applied to hospitals.

Senator DOLE. Finally, one question that keeps popping up is the automatic wage passthrough. Senator Schweiker addressed it; Secretary Califano, I do not think touched on it much in his statement.

Do you believe that nonsupervisory personnel are so underpaid that we need to have the automatic passthrough, or can we approach it as Senator Talmadge has, maybe on some local basis or regional basis?

Mr. McMAHON. We are very much concerned about a mandatory wage passthrough for nonsupervisory personnel. We think it removes constraints. It does not take into consideration fringe benefits, overtime pay, nor the impact on the supervisory wages. As Senator Talmadge's questions indicates, it does remove managerial flexibility and the ability to live with the cap. We much prefer the approach that Senator Talmadge has taken. We feel that it is better to see just how that hospital compares with its peers in the wage costs on an area basis.

There are, undoubtedly, areas that have not kept up. I think, as a whole, the nonsupervisory wages in hospitals over the period of the last 10 years, since minimum wage, since medicare and medicaid, have caught up, so we have very much concern and very real concern

about the removal of the restraint that is inherent in any kind of mandatory passthrough.

If there were areas—and I listened to the questioning of Senator Schweiker—if there were areas where a problem can be identified and there is a passthrough in those areas, it might be better that we think of the service area approach in Senator Talmadge's bill as a better way to proceed.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, Mr. McMahon. We appreciate your contribution to our deliberations.

[The prepared statement of Mr. McMahon follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me today is Leo J. Gehrig, M.D., Senior Vice President. The AHA represents some 6,500 member hospitals, long-term care institutions, mental health facilities and hospital schools of nursing, and over 24,000 personal members. We appreciate the opportunity to appear before this subcommittee.

Our presentation today will include a discussion of the nature of hospital cost increases and will review S. 1391, both as originally introduced and as reported by the Senate Committee on Human Resources, and your additional specification for an alternative approach to hospital cost containment related to S. 1470.

The Administration's bill and S. 1391 as reported by the Senate Committee on Human Resources do not consider the total health delivery system, but rather only its hospital component—one segment of an extremely complex and interdependent system of providing health care services to the citizens of the nation. These bills do not address the multiple factors which determine hospital costs, but would merely limit revenues to institutions.

HOSPITAL COSTS AND EFFORTS TO CONTAIN THEM

The fact that hospital and health care costs are increasing at a rapid rate is not in dispute. Health care cost increases are a complex problem; to address the issue requires the combined efforts of all providers, consumers, and government and other third-party payers. Hospitals are concerned and are working actively to restrain health care cost increases within their control. Therefore, as we seek to bring the increase in health care costs more in line with the growth of the general economy, it is essential that the actions taken be constructive to this end. It must be recognized that this objective cannot be accomplished in a relatively short time.

Hospital cost increases result from a variety of factors, including general inflation, the intensification and improvement of services, modernization and maintenance of service capacity, expansion of manpower resources, increased demand for services, and compliance with government regulations. Although the Consumer Price Index (CPI) reflects inflation in the general economy, it is inappropriate as an index of the impact of inflation on the goods and services that hospitals must buy. Moreover, the CPI does not reflect the impact of increased intensity in hospital services.

The hospital market basket includes many items that have risen much faster than the CPI. The AHA, therefore, has developed a hospital cost index (HCI) and a hospital intensity index (HII) which are based on the price and utilization of 37 service elements common in the delivery of care to patients. These more typically reflect the hospital market basket. Using these indices, we have found that of the 15 percent rise in hospital costs last year, 10 percent was purely the result of inflation. The remaining 5 percent resulted from increased intensity and improvement in patient care.

Payment reform is only one part of an array of government and private programs under development or in existence that deal with the problems of health care costs. The American Hospital Association is committed to the pursuit of a reasonable solution to this problem which would promote efficiency and not jeopardize access to delivery of quality health care. While we have stated the opposition of the AHA to the administration's hospital cost containment bill, we

are by no means negativistic with regard to viable alternatives for the containment of health care costs. Neither do we feel any less committed to seeking solutions to the nation's problems of health care costs than is the Federal Government.

In addition to advocating multiple cost containment approaches, the American Hospital Association and its member hospitals have sought and continue to seek ways of conserving health care resources. Many hospitals across the country, in addition to their usual management activities, have developed special cost containment efforts. While the association does not at this time have complete data on these activities, our information from many sources points out savings through projects which will have continuing long-term benefits, as well as projects that result in one-time savings. These efforts include a wide variety of approaches such as the conversion or closure of underutilized resources; the development of shared services with other institutions; changes in the methods of providing hospital support services; and cost saving changes in hospital staffing patterns.

Mr. Chairman, inasmuch as we have dealt with specific cost containment approaches supported by AHA in previous testimony, I will not reiterate details today, but would like to cite the variety of programs aimed at conservation of resources, some of which are in developmental stages and others yet in the process of formulation through legislative and administrative initiatives, State and Federal. Among the leading efforts is comprehensive health planning and the development of local community planning. Our Association has urged and continues to urge the development of strong certificate of need laws at the State level to avoid the development of duplicative or unneeded health resources and to coordinate the allocation of available resources. Similarly, we have supported improved utilization review and medical auditing to ensure both quality of care and appropriate use of resources, and have advocated the development of State-level rate review systems under Federal guidelines to assure the public that hospital costs and rates are reasonable and appropriate.

In addition, AHA fully endorses antifraud and abuse legislation to strengthen the capability of government to detect, prosecute, and punish fraudulent activities under medicare and medicaid, as embodied in your bill, S. 143; backs the philosophy that government has an obligation to analyze the cost benefits of regulations it imposes on hospitals; promotes greater public disclosure of hospital cost data in order to enable the public to make more informed choices in the use of health services; and supports greater exploration of the restructuring of copayments and deductibles to stimulate increased consumer cost consciousness in decisions related to the utilization of health care services.

THE ADMINISTRATION'S BILL—S. 1391

The American Hospital Association strongly opposes enactment of the administration's original plan for cost containment, S. 1391. It is our firm belief that enactment of this bill would seriously jeopardize the present and future ability of hospitals to provide quality care to the American people. We will not review all of the problems inherent in this bill, but will concentrate our discussion on the major issues.

The overall design of the various controls in the bill is ill-conceived. While the bill would seem to allow some flexibility of controls by permitting a state rate review option, it severely limits such an option. Specifically, the intent of the bill is that hospitals in certain states, which already have their own rate review programs that would meet criteria established by the act, could be exempted from the Federal hospital cost containment program. Unfortunately, only five to seven States could possibly meet the conditions of this provision. In order to be exempted, the Governor of a qualifying state would be required to certify that the program in his or her state would not allow the aggregate rate of increase to exceed the inpatient revenue limit established by the Secretary of HEW—without regard for the additional allowances which would be provided through the "wage pass-through" and limited exceptions provisions of the bill. This means that states would have to apply even more stringent controls on hospitals than would be required under federal administration of the program.

The concept of the "can" is presented in S. 1391 as transitional: however, there is no language in the bill limiting its application to any specific period of time, and it is suggested by some administration representatives that the program would in all probability be in place well into the 1980's.

Any consideration of equity in this plan is entirely foregone in the interest of easing the federal administration of the hospital cost containment program. The approach of using uniform percentage limits on increases in revenues embodied

in this proposal would exert the heaviest pressures where they are least appropriate—on the most efficient hospitals. While this formula is intended to squeeze out excessive costs, the efficient hospital could only curtail essential services and sacrifice the quality of care in order to survive with the formula constraints.

We also find significant problems in the application of the basic control formula. The Secretary has said that the cap would result in a 9 percent limit on year-to-year increases, allowing approximately 6 percent for inflation and 3 percent for increased intensity and improvement of services. Actually, even if it allowed a revenue increase of 9 percent for the first year, thereafter the application of the revenue limit to the base year—together with the direct effect of the increased formula—would have a ratchet effect and severely screw-down the revenue ceiling over time. According to a Congressional Budget Office analysis, the result in future years would be a screw-down of the revenue increase limit to approximately 5 percent in 1982, which would be less than the estimated rate of inflation in the general economy.

Another concern with the application of the "cap" is that it would be applied retroactively. For hospitals with fiscal years beginning other than October 1, the controls as provided in the bill would apply to prior operating periods. In addition, the "cap" would be applied separately to payments from each third party cost payer (such as Blue Cross, Medicare and Medicaid) and all charge payers (such as insurance companies and individuals who pay their own bills), thus establishing limits on payments from each class of purchaser. Because of these limits by class of purchaser, losses incurred by hospitals as a result of inadequate payments by a purchaser such as Medicaid, or as a result of charity care or bad debts, could not be compensated for by charge increases to other payers.

A serious flaw in the bill is that it provides very limited bases for exceptions. Those provided relate primarily to major increases in services. But regardless of such increases, a hospital's request for exceptions to the revenue limit would be considered only if its current ratio of assets to liabilities (taking into account all other available resources) placed it in the bottom quartile of all hospitals covered by the program. In other words, no matter how justified an exception request might be, it would not be considered unless a hospital was threatened with insolvency.

Mr. Chairman, I believe I need go no further in explaining the American Hospital Association's clear and open opposition to this arbitrary and inequitable proposal.

S. 1391 AS REPORTED BY THE SENATE COMMITTEE ON HUMAN RESOURCES

The Association also opposes the proposal which has emerged from the Senate Committee on Human Resources, S. 1391. Our opposition to this version of the hospital cost containment proposal is that it retains the fundamental concepts of many of the defects of the administration's bill.

A significant improvement in this version of the bill is its provision for delegation of cost containment programs to States, allowing the participation of States that presently do not have such programs. In addition, a variety of State payment control methods would be permitted under this provision. The Secretary of HEW would be authorized to make grants to States to assist in the implementation of these cost containment programs. Such State programs would have to assure that the aggregate rate of increase in revenues for all hospitals would not be less than the GNP deflator, nor exceed 110 percent of the national inpatient revenue limit. Similar to the effect of the administration's original proposal, this 110 percent upper limit would require a State program to be more stringent than the program administered at the Federal level.

The bill would mandate wage and salary "pass-throughs" for nonsupervisory personnel. Under only one circumstance would such "wage pass-throughs" not be mandatory, and that would be in States with existing cost control programs which would qualify for exemption from the Federal program. These mandatory "wage pass-throughs" would not take into consideration increased wage costs resulting from fringe benefits, shift differentials, overtime pay, or the "ripple effect" that such wage increases would have on the wages of other hospital employees—increases which would be necessary to maintain a consistent wage structure. The policy on this issue would not be consistent across the country and, while such "wage pass-throughs" would appear to promise total exemption for wage increases on behalf of nonsupervisory employees, they clearly would not do so.

The details of the provision for application of the revenue cap have been changed in this version of S. 1391. The inpatient revenue limit included in this bill

would be applied to the previous year's allowable revenues rather than the revenues of the base year. On the other hand, the "cap" would continue to be calculated on a formula basis which has a ratchet effect.

The class of purchaser methodology would continue to be used, imposing the same limitations on hospitals that would exist under the administration's original proposal.

In addition, the bases for exceptions would be largely unchanged. However, provision was made for exceptions for cost increases related to changes in benefits, reimbursement methodology, and patient mix among payers; and a change was made in the insolvency test for consideration of exception requests. While important, these modifications are nonetheless inadequate.

Mr. Chairman, other modifications were made in this version of S. 1391, some of which appear to mitigate the severity of the original proposal and others which would make the program more complex. Nevertheless, because the measure would create the basic problems we have identified in the administration's original arbitrary "cap" proposal, and would result in inequities for hospitals and the patients they serve, our association firmly opposes it.

ADDITIONAL SPECIFICATIONS RELATED TO S. 1470

Mr. Chairman, the American Hospital Association believes that S. 1470, the Medicare/Medicaid Administrative Reimbursement Reform Act of 1977, which you introduced, identifies and constructively addresses a number of critical issues. We know that you recognize the unique characteristics of the health care delivery system, and S. 1470 reflects this understanding and consideration of its complexities.

Your bill, in revising the method of payment to hospitals for routine services, would establish a system of incentives and disincentives based on average costs for groups of essentially similar hospitals. At the conclusion of hearings in June, you further stated that you intended to have your staff explore the potential for the expansion of the proposal embodied in S. 1470 so that it would cover ancillary service costs and be applicable to all payers for health care services.

Our review of your alternative proposals for hospital cost containment is based on the committee's outline of specifications released last week. Since there are important aspects of this outline which have yet to be developed and since there is incomplete knowledge of how such a system would operate, it is necessary that we temper our remarks today. Moreover, because it has not been possible for a broad review of this alternative by our membership, we are not in a position to speak with confidence concerning our views. However, we wish to compliment you and your staff for these efforts.

State-level cost containment programs

We strongly support the provision which would permit state-operated rate review programs as an option to federally-administered controls. Your draft specification acknowledges that State hospital regulatory activities could be accepted in lieu of the Federal controls where they apply to the same hospitals as the Federal program and where they are determined, in the aggregate, to limit hospital revenues in a State to a level no greater than permitted in a Federal program. We believe that a delegation to States should be made, within the framework of Federal guidelines, which would not only establish the limits of increase that would be permitted, but also assure that payments to providers are equitable and are at least adequate to meet the rate of inflation in the general economy. Further, in encouraging the development of such State level action, it is important that the Federal guidelines provide a degree of flexibility in the specific requirements which a State program must meet in order to permit a fair evaluation of its effectiveness.

While we endorse the delegation of cost control activity to States, we believe that some existing voluntary programs—and others which may be developed—could, under State sanctions, carry out this function very effectively. We recommend that States should have the authority to utilize such voluntary programs.

The AHA believes that an effective State rate review program can assure the public that hospital costs and rates are reasonable and appropriate. Such a State program can provide for individualized hospital review, consideration of community characteristics and coordination with local planning decisions. It must include the participation of all payers and recognize the legitimate financial requirements of hospitals necessary for the provision of services to

their communities. Further, any such State-based review program should permit the development and testing of alternative payment methods and their evaluation.

We would urge that you and your committee include in your bill funding for the encouragement and assistance in the development of State-level review programs along the lines of the provision included in S.1391, as reported by the Senate Human Resources Committee and as is presently being considered by committees in the House.

Limits on routine service revenue

Your alternative approach for establishing limits on total routine service revenue builds upon the original Talmadge proposal for the comparison of routine service costs by essentially similar hospitals. We have recognized the important strides that were made in excluding from such comparisons obvious cost factors which are beyond the control of institutional management and, in fact, vary without regard to the efficiency of institutions.

Despite these advances, I believe all will agree that any classification methodology for hospitals is in the initial stages of development. We are concerned, as you are, that any classification scheme should effectively differentiate between efficient and inefficient operations and not unintentionally penalize a provider. Some of our past expressed concerns about the classification system include a lack of sensitivity to geographical differences other than in terms of wages, the inadequacy of the data base in comparing regional wage differences, and the difficulty in accounting for certain other variables of hospital operation such as case mix, length of stay and intensity of services.

We recognize that your specifications speedup implementation of the reimbursement reform program. Unfortunately, such acceleration would preclude opportunity for the development, collection and evaluation of certain data important to the program. Therefore, we believe that such a control program should include flexibility to permit the timely consideration of exceptions and correction of erroneous forecasting.

We agree that the adjustment of wage levels on a geographic basis is an important variable in comparing hospital costs. Similarly, S.1470 provided for consideration by the Secretary of HEW of price differences in two states, Alaska and Hawaii. We believe that such an adjustment is appropriate and should be provided for these and other States that demonstrate significant price variations.

In establishing a total limit on routine per diem operating revenues, your specifications indicate that in the initial control year the revenue limit would be established at 120 percent of the average per diem cost for these same services in a group of similar hospitals. This per diem revenue limit for that year would also be the upper limit for cost reimbursement for routine services. In subsequent years, the routine per diem revenue limit would be equal to 103 percent of the increase in the average routine per diem cost of a hospital's classification group. During the next few weeks we will study the implications of this approach of limiting routine revenues on motivating hospitals to pursue further cost containment efforts.

Limits on revenue for ancillary services

Despite considerable progress by your staff in developing a classification method for medicare/medicaid reimbursement for routine per diem services, the present state of the art does not make it feasible for this method to be reasonably extended to reimbursement for ancillary services. In establishing revenue limits for ancillary services, your specifications would provide for individual hospital calculation of its average per admission revenues for ancillary services in the base year, with certain adjustments to update the base period to the effective date of the program. In subsequent control years, the per admission revenue limit would be modified by the application of indices which would reflect changes in prices of nonwage goods and services hospitals purchase and changes in prevailing wage rates regionally determined.

In bringing the 1976 base year cost data forward 2 years to the first year of the control program, a hospital's actual cost increases for ancillary services in the first year would be assumed to be identical in the second. We understand the necessity for this assumption because of the lack of actual cost data at that point for the hospital's second interim year. Since this estimating procedure may not

reflect actual increases in ancillary costs, provisions would have to be made for correcting errors in such projections.

In subsequent control years, the revenue limits on ancillary services would be adjusted for wage and nonwage cost increases. We appreciate your recognition that adjustments for hospital nonwage cost increases should be reflective of the mix of goods and services hospitals must purchase. The use of a hospital market basket for developing such an index does acknowledge the hospital industry's cost of providing services, which is not reflected in known indices that use general economic indicators (e.g., the Consumer Price Index and the GNP deflator).

Since the index for nonwage cost components called for in your specifications is not yet developed, its precise impact cannot be evaluated at this time. If a hospital input index is developed by the Secretary, the AHA would provide him with available data and experience which we have developed for this purpose.

Although not reflected in your specifications, I understand from your staff that admission volume adjustments of ancillary service revenue limits would be as follows: For a hospital experiencing a decrease in admissions to levels between 90 and 100 percent of its past year's experience, it would be provided a new revenue limit, calculated as if admissions had not changed. For a hospital experiencing admission decreases below 90 percent of its prior year's experience, 50 percent of the cost of such admission decreases would be deducted from its last year's ancillary service revenue limit. For an institution having admission increases ranging between 100 and 102 percent of its prior year's experience, its new revenue limit would reflect the full cost of all additional admissions. On the other hand, admission increases above 102 percent of a prior year's experience would result in increases equal to 50 percent of the average cost of such increased admissions. Further, your specifications recognize that predetermined ratios of fixed to variable costs associated with levels of admissions are not uniformly predictable for hospitals. You have provided that where such automatic volume adjustment changes result in revenue limits which are inadequate to meet actual costs, an exception could be sought. We believe this is essential.

Your provision that operating costs associated with capital expansion projects that are approved by health planning agencies is necessary and most commendable. It is essential that revenue limits accommodate the operating needs of approved projects coming on line and those that will be approved in the future.

While we have been supportive of the provisions of your bill to reform reimbursement for medicare and medicaid services through the use of a classification system which would be utilized to establish target rates for routine service costs, we are concerned, because of the state of the art, that your specifications or revenue limits for ancillary services must be based on average percentage increases. Certainly your use of more specific indices for determination of such percentages is sensitive to the costs that hospitals must incur to provide services for their patients. As I have indicated previously, we would be most willing to continue to work with you in seeking a more adequate methodology.

We thank you, Mr. Chairman, for the opportunity to express our views on these bills and will gladly answer any questions you and members of your subcommittee may have.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION ON H.R. 8423, AMENDMENTS TO THE MEDICARE RENAL DISEASE PROGRAM

The American Hospital Association, representing some 6,500 member hospitals, extended and long-term care institutions, mental health facilities, and hospital schools of nursing, and over 24,000 personal members, expresses its appreciation for this opportunity to comment on H.R. 8423.

The American Hospital Association has long encouraged hospital participation in the end-stage renal disease (ESRD) program. Currently, some 464 hospitals have submitted applications to the Social Security Administration for certification as either renal disease centers, renal transplantation centers or renal dialysis facilities. While hospitals are currently providing direct services to renal patients, many of them also provide support to other end-stage renal disease facilities through training programs, access to highly specialized professionals, and selected services not otherwise available to patients in the program.

We understand that the purpose of H.R. 8423 is to amend the ESRD program by providing better coverage for patients and establishing new incentives for the use of more cost effective methods of treatment. While we endorse these

objectives, we would like to comment on several specific provisions of the bill and include recommendations which we believe will enhance the effectiveness of this important Federal health program.

Eligibility

We are pleased with the changes suggested for patient eligibility under medicare for renal dialysis coverage. We support the bill's provisions for immediate medicare coverage for patients who are admitted as inpatients to an institution in preparation for kidney transplant surgery, but we believe that requiring that a transplantation must occur within three months of hospitalization may create unanticipated financial burdens on patients. We are concerned that an inflexible requirement for immediate transplantation does not recognize those instances in which planned transplantation must be postponed temporarily in the best interest of a patient, or because of circumstances beyond the control of the physician or of the institution. In such cases we do not believe that a patient should forfeit eligibility for medicare coverage.

Transplantation

We believe that H.R. 8423 will encourage patients to seek transplantation as a means of overcoming disability resulting from end-stage renal disease. Transplantation is an option that may facilitate the return of patients to full and productive lives and may eliminate the need for continuing dialysis. Accordingly, both the patients and the ESRD program benefit.

Earlier provisions for ESRD coverage penalized a patient who underwent renal transplantation if the transplanted kidney was rejected or failed to function and the patient was required to return to the life-sustaining benefits of renal dialysis. Under current law, individuals who experience transplantation failures which occur more than one year after transplantation must wait three months to become eligible once again for coverage under medicare. Such a requirement creates serious difficulties for some patients and their families. Therefore, we support the provision for immediate coverage of dialysis costs for patients who experience post-transplantation failure and the extension of the post-transplantation coverage period from 12 months to 36 months.

Finally, we support the bill's provisions to reimburse for all reasonable costs related to the necessary hospitalization of a kidney donor, including coverage for the medical costs of the donor for up to two months following the removal of the kidney. By eliminating copayments, this provision removes an important financial barrier to the donation of kidneys, which is particularly important when the donors are family members of the patients. The success rate of kidney transplantation increases significantly when the kidney is acquired from a donor closely related to the recipient and, therefore, high priority should be given to reducing financial barriers to kidney transplantation in families which already must bear direct and indirect costs related to the treatment of kidney disease.

Self-dialysis

The American Hospital Association supports self-dialysis as a cost effective method of providing renal dialysis for some patients with chronic renal failure. Efforts to encourage self-dialysis as a way of reducing the cost per dialysis are important when one compares the cost of similar treatment in renal dialysis centers and facilities. Self-dialysis also appropriately increases the patient's responsibility for the contribution to his own treatment needs and returns to the patient a greater degree of control over his own care.

The AHA applauds the incentives in this bill to encourage facilities and individuals to participate in self-care dialysis training programs by providing immediate coverage when an individual participates in a self-care dialysis training program prior to the third month after he or she initiates a regular course of renal dialysis. We are pleased that the provisions of this bill recognize the four treatment modalities in which ESRD patients could be eligible for benefits—institutional dialysis, transplantation, self-care dialysis, and home dialysis. We believe each has an important role in the ESRD program.

Current regulations require institutional renal facilities to be utilized at specified levels to be eligible for medicare reimbursement. ESRD facilities which succeed in reaching the bill's national objective of a majority of new patients on self-dialysis or identified as candidates for transplantation may not as a consequence be able to meet the minimum inpatient utilization requirements now established by program regulation. If these utilization requirements are not met,

the facilities could be forced to close. This would then eliminate support facilities which otherwise would be available for self-dialysis or home dialysis patients who develop complications and require hospital dialysis. These patients would be forced to seek medical support services from other facilities which may be unable to cope with such increased demand or which may not be reasonably accessible to such patients.

Before a recommendation is made to close an ESRD institutional facility due to underutilization, consideration should be given to the need for backup facilities for self-dialysis patients, the estimated increase of patients with chronic renal failure, and the need for reasonably accessible facilities within the network area. Therefore, we urge that the utilization standards be appropriately modified for ESRD facilities which are meeting the national objectives called for in this legislation when the HEW Secretary determines that such modifications are necessary to meet the needs of renal patients in the network area.

Recommendation: On page 6, section 1881(b)(1)(A), the bill should be modified to read, "(A) shall include requirements for minimum utilization rates for covered procedures including self-dialysis training and end-stage renal disease facilities, which meet the national objective of having a majority of patients either receiving kidney transplants or being placed in programs of self-dialysis, should be eligible for a modification of the minimum utilization standards as determined by the Secretary."

It may not be possible or desirable for all renal dialysis facilities to meet minimally established self-dialysis utilization rates among its group of ESRD patients. The medical decision to prescribe self-dialysis must include assessment of the physical condition of the patient, the psychological and emotional state of the patient, and the social constraints to self-dialysis. Untoward findings in any of these areas of assessment may preclude self-dialysis.

Hospitals also are concerned that minimum utilization requirements for self-dialysis may not consider the characteristics of the population served by a facility. For example, institutions serving populations that are predominantly renters of living space, in contrast to homeowners, may be unable to encourage a maximum number of patients to enter a program of home dialysis because of the structural changes involved and the resistance of landlords to structural changes in their property. Further, such factors as a family's religious beliefs, its stability as a unit, and economic status may pose barriers to self-dialysis or home dialysis. The lower cost of such dialysis and the increasing self-reliance of patients make it important to recognize that efforts to encourage self-dialysis are desirable, but national objectives for a majority of new patients to receive kidney transplants or to enter programs of self-dialysis should serve as guidelines and not be inflexible requirements because of the varying circumstances of individual patients.

The American Hospital Association is pleased to see provisions for reimbursement for costs of supplies, equipment, support services as well as installation, maintenance, and repair of equipment in home dialysis programs. This would eliminate some of the underlying problems that home dialysis patients have faced in view of existing regulations which do not cover these items.

Recommendation: The provision on page 15, section 1881(C)(4), should be modified to indicate that the national objective that a majority of new patients receive kidney transplants or enter self-dialysis programs should serve as a guideline and not as an inflexible requirement for end-stage renal disease facilities.

Networks

Because ESRD network coordinating councils and medical review boards are already mandated by current regulations, AHA believes that the requirements and functions of networks should be coordinated with Professional Standards Review Organizations, hospitals delegated PSRO responsibility, and Health Systems Agencies (HSAs) as established in Public L. 93-641. We are concerned that H.R. 8423 does not require a working relationship between those agencies and organizations. Existing regulations for coordination between renal network coordinating councils, HSA's, PSRO's, and renal medical review boards fail to provide for coordination of these entities and they are not structured to allow a coordination of functions of the concerned groups.

Recommendation: When appropriate, network coordinating councils should be subject to planning constraints of either a single HSA or a State Health Planning and Development Agency. When a network services more than one State, the network coordinating council should include representation from each HSA that has

jurisdiction within the renal network coordinating council. This provision should be incorporated in the bill under section 1881(C) (1).

Recommendation: A relationship between the ESRD medical review boards and Professional Standards Review Organizations should be specified through written agreements to require coordination of activities when the area served overlaps in whole or in part. This provision should be incorporated into the bill in section 1881(C) (1).

Reimbursement for dialysis

While the American Hospital Association strongly supports the principle of establishing coinsurance requirements for patients who have third party insurance for medical care coverage, we believe that coinsurance provisions should allow for sliding scales based on the patient's ability to meet copayments. Serious renal disease requires continuing medical supervision and, not infrequently, long-term institutional care. The debilitating effect of the illness often creates such physical deterioration that patients are unable to generate sufficient income to meet even basic subsistence requirements. This situation may be further complicated by the inability of patients to obtain copayment benefits in certain states because of the ways in which some Medicaid programs are administered. Not infrequently, the financial loss to the ESRD facility must be borne by other patients in the hospital.

In addition, we are concerned about the provision on page 7, section 1881(2) (B) (ii), that the Secretary would determine the amount of payments for part B services on a basis other than actual cost or charges. If a hospital bills for physicians' services, that hospital should not be required to underwrite a patient's coinsurance portion of the physician's charge.

To help the Secretary set reimbursement rates for a fiscal year, we urge that ESRD facilities be consulted annually, so that their cost experiences are reflected in rates established by the Secretary.

Recommendation: Amend section 1881(b) (2) (A) on page 6 to read, "With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end-stage renal disease for which payments may be made under part B of this title, such payments (unless otherwise provided in this section) shall be equal to 80 percent of the amounts determined in accordance with subparagraph (B) and with respect to payments for services for which payments may be made under part A of this title, the amounts of such payments (which amounts shall not exceed, in respect to costs in procuring organs attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1861(v) except that such payments shall be equal to 80 percent or more, based on the patient's ability to pay. Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of up to 20 percent of the cost for such services based on the patient's ability to pay for such services (as determined in accordance with subparagraph (B)) and the deductible amount imposed by section 1833(b)."

Recommendation: Amend section 1881 (b) (2) (B) to read, "(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end-stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including any basis authorized under section 1861(v)), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals. Such regulations shall provide for the implementation of appropriate incentives for encouraging more efficient and effective delivery of services (consistent with quality care); and shall include, to the extent determined feasible by the Secretary, prospectively set rates, a system for classifying comparable providers and facilities, and target rates with arrangements for sharing such reductions in costs as may be attributable to more efficient and effective delivery of services. During the last quarter of the calendar year ESRD facilities should be provided an opportunity to present to the Secretary, based on their previous cost experience, projected cost data for the subsequent fiscal year. This data should be used by the Secretary as the basis for establishing the new prospective rate."

The American Hospital Association supports this legislation with the above changes incorporated. Thank you for the opportunity to express our views on this proposed legislation.

Senator TALMADGE. The committee will stand in recess until 8 a.m. tomorrow morning.

[Thereupon, at 10 a.m., the subcommittee recessed, to reconvene Thursday, October 13, 1977, at 8 a.m.]

HOSPITAL COST CONTAINMENT AND END STAGE RENAL DISEASE PROGRAM

THURSDAY, OCTOBER 13, 1977

**U.S. SENATE, SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
*Washington, D.C.***

The subcommittee met, pursuant to recess, at 8:30 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman B. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge and Dole.

Senator TALMADGE. The subcommittee will please come to order.

We are under extraordinary time constraints this morning. The subcommittee is meeting at 8 o'clock; the full Finance Committee is meeting at 10 o'clock. We will have to allow time between our hearings to arrange the room for the full Finance Committee to meet; that will take some time.

So each witness will be limited not to exceed 10 minutes.

The first witness is Mr. Bernard R. Tresnowski, executive vice president, Blue Cross Association. We are delighted to have you with us, sir. You may insert your full statement in the record, and summarize it if you will.

STATEMENT OF BERNARD R. TRESNOWSKI, EXECUTIVE VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. TRESNOWSKI. Mr. Chairman, I am Bernard Tresnowski, executive vice president, Blue Cross Association, the national coordinating agency of the member Blue Cross plans of the United States and Puerto Rico.

We thank you very much for the opportunity to share with you our thoughts on what must be done over both the short and longer terms to help contain health care costs and on certain specific legislative proposals developed to achieve that objective.

The views in the full statement reflect the knowledge and experience gained by the Blue Cross organization through the administration of both public and private health care financing programs.

The symptoms and causes of current problems in the delivery of health care services are many and complex. Medical technology is often widely introduced into the system without careful evaluation of its value and cost-effectiveness in comparison with alternative techniques. There is unnecessary and costly duplication of expensive facilities, equipment and services by health care providers in many

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communities. There are wide disparities in the patterns and rates of hospital admissions and other service use from community to community with no identified differences in final results. And significant variations can be seen among hospitals of like size and nature in terms of internal productivity.

Clearly, the right incentives are not in place for health care providers to effectively eliminate those problems. Our hopes for the future in identifying, testing and using effective incentives rest on the shoulders of a variety of participants—Federal and State government, private third-party payors, health care providers themselves, and labor and business.

While we may not have yet identified the incentive structure that will work, it is increasingly clear that it must include several well-integrated and mutually supportive elements: improved health care planning and utilization review programs; better financial incentives in provider rate-setting or payment systems that complement health planning and UR initiatives and promote better day-to-day provider efficiency; alternative, competing systems of financing and delivering health care services such as HMO's or hospital-only capitation payment systems; and improved health care benefits in such areas as home care and second-opinion surgery to promote care in the least costly but medically appropriate setting.

While it will take some time, given the current state of knowledge, for those cost-containment tools to be well-designed, effectively integrated and put to work on a broad scale, there is a serious economic problem with respect to health care costs generally, and hospital costs specifically, that needs immediate attention. The challenge is how to insure some economic relief over the short term, while stimulating, or at least not inhibiting, improvement in the design and operation of cost-containment or incentive mechanisms which have potential for longer term, more permanent and more effective containment of health care costs. There is a tendency to look for simple, permanent solutions now—such as State regulation of hospital rates or major, longer term reforms in medicare and medicaid reimbursement. But without enough experience with any single approach, its broad application might not only fail to solve the problem, but could make it worse.

To provide some immediate relief, without inhibiting the movement toward permanent and effective reforms, we recommend a program to be enacted now consisting of two components: (1) a national moratorium on new plan capital expenditures, to be followed by a more permanent capital limitation program; and (2) a program to limit hospital inpatient revenues.

Health care planning—if effective at the institutional, community and State levels—represents the most critical element in more permanent and effective containment of health care costs. However, most health care planning is not now effective, primarily for two reasons.

First, many health care planning agencies at the State and local level are new, and have not had enough time to develop well-thought-out health care plans or to create workable procedures.

Second, the system of health care planning that is emerging under Public Law 93-641 has no provision for plant capital limits to be established at the State and local levels. At these levels, health care service needs and the capital projects to meet them can be listed and

established at the State and local levels. At these levels, health care planning cannot succeed if it only identified needs, but does not determine which are needed first, which are affordable and which are not.

To be effective, the authority and responsibility for establishing realistic capital budget constraints, as well as any related standards for health care service capacity and use, should rest primarily with State and local planning agencies. That is especially true over the next few years. We believe it would not be effective or practical for the Federal Government to impose rules upon State or local health care planning agencies—either strict capital dollar limits or strictly supply and use standards for health care plan development or review. Such budgeting limits and standards must be permitted to evolve logically at the local and State level within broad Federal guidelines—such as the sound “bottom-to-top” planning that Congress wrote into Public Law 93-641.

An immediate moratorium on new plant capital expenditures would give State and local health care planning agencies some breathing space not only to develop good plans and generally gear up for effective review of project proposals, but also to establish a type of capital limit that is needed. Also, if broadly applied to various types of health care providers, a moratorium would also help to prevent unnecessary and inefficient movement of equipment and services away from hospitals that would be subject to revenue limitation.

A moratorium program should include tight criteria and allow only capital projects which are already obligated, are specifically directed at eliminating excess operating capacity or are aimed at correcting life and safety hazards associated with needed health care facilities or services. Also, the moratorium should apply to virtually all medicare part A and part B providers.

Enforcement of the moratorium should be primarily through section 1122 of the Social Security Act extended to all States whether or not they have a designated planning agency agreement with the Secretary of Health, Education, and Welfare. The moratorium should cease to apply in a particular State when the State health planning agency is fully designated by the Secretary and meets all existing requirements of Public Law 93-641, as well as the new capital limit program.

Under both a moratorium and long-term capital limit program, ways need to be found to create financial incentives for health care providers to reduce or eliminate excess operating capacity. This could mean closing or converting portions of a hospital where appropriate fixed costs need to be recognized by all payors. A Federal and private grant and reimbursement program may be needed to defray certain fixed costs, such as long-term debt retirement and severance pay for employees, associated with closures or conversions. In addition, a long-term capital limit program administered by a fully designated State health planning and development agency should allow appropriate increases in a State's dollar limit where capacity is eliminated.

An interim national program to limit hospital acute care revenues must be simply designed with limited exceptions. We would also note that there is very little operational experience to help design and implement a revenue limitation program that is equitable to both

hospitals and consumers; and that is administratively simple and effective. An arbitrary revenue limitation program poses certain dangers to the effective delivery of health services. For these reasons, the interim program should allow for exemptions and designation of a specific termination point after a more permanent program is in place and effective.

We believe there must be exemptions from the Federal revenue limitation for programs developed by clusters of hospitals working with third-party payors that guarantee results. The results would be either:

One, a guarantee that a group of hospitals in the exempt program combined would not exceed the increase limitation requirements—including exceptions and passthroughs—of the national program; or

Two, a guarantee by a group of hospitals in a defined area that their program for cost containment would:

(a) change the structure, through introduction of utilization review programs, innovative reimbursement techniques, mergers of hospitals, consolidation of hospital services, et cetera, of the health care delivery system, or some part of it in their area;

(b) contain the rate of increase in costs of participating hospitals to a level below that which prevailed previously for those hospitals.

In our full statement, we provide detailed comments on S. 1391, reported out of the Senate Health Committee. I will not comment on that bill now, but am prepared to respond to your questions, if necessary.

As to the amendments to your bill, S. 1470, alternate approaches, to hospital cost containment, we would note that we are pleased that this revenue containment program can start soon and will apply to all hospital inpatient care and to all payors. Although we have not calculated precisely the impact of each of the separate elements, we surmise that if general hospital prices would rise by 60 percent, the revenue limit per day could rise between 10 and 13 percent. Greater utilization and total expenditures for hospital care might even be greater.

The proposal provides an opportunity to reduce total expenditures by reducing the allowable limit for routine operating costs by 20 percent above the peer group average, the first year depending on the rate of escalation. If this aspect of the approach were combined with features that limit the rate of increase and the average itself and those features were tied into utilization and control and admission and days of care, the total effect could be significantly lower rates of expansion in expenditures for hospital care.

I would also note that we are concerned that the proposed excise tax can become an indirect tax on those who pay premiums for hospital insurance to the extent that there is overpayment. This is because any excise tax collected will go to the U.S. Treasury, not to the patients or payors.

We have offered comments on H.R. 8423, dealing with the end-stage renal program. We very much appreciate the opportunity to present our views on this important matter this morning.

Senator TALMADGE. Thank you very much, sir.

Yesterday, I asked Mr. McMahon several questions concerning the situation with respect to hospitals in this country. I would like to get the Blue Cross Association replies to the same questions.

First, does your association believe that there is substantial duplication and overlap in equipment and services in many hospitals in this country?

Mr. TRESNOWSKI. Yes, there is.

Senator TALMADGE. Second, does your association believe that too many hospitals are ordering and installing CAT scanners?

Mr. TRESNOWSKI. Yes, much too many.

Senator TALMADGE. Third, does your association believe that overall we have a surplus of hospital beds in this country?

Mr. TRESNOWSKI. Yes, we do.

Senator TALMADGE. Does your association believe that a substantial number of hospitals are incurring excessive costs?

Mr. TRESNOWSKI. Incurring excessive costs?

Senator TALMADGE. Yes.

Mr. TRESNOWSKI. In terms of the structure that is there now, the production function, I think that the costs are generally appropriate. It is not in the productivity of care in an individual hospital that the excessive costs occur. It comes through the proliferation of too many hospitals and too many beds.

I do not know if that is responsive. There is a distinction.

Senator TALMADGE. We appreciate your generous support of the suggested approach toward hospital cost containment. We, too, recognize the need to undertake further work. We would appreciate your providing us with any suggestions you might have as to specific means of dealing with the technical matters. Could you please do that?

Mr. TRESNOWSKI. We would be very happy to.

Senator TALMADGE. Thank you very much.

Senator Dole?

Senator DOLE. On the end-stage renal disease program, you make one statement, I think, that deserves some attention. The decision to dialyze in the home or accept a transplant is based on medical, social, and psychological judgments and not on economic reasons only, because it is a very costly program. I am sure that we need to find some way to control the spiralling costs, but there have to be other factors than economic factors considered.

I appreciate that statement.

Mr. TRESNOWSKI. Certainly, you want to encourage home dialysis. The American Medical Association's statement, which they will be presenting later, I think they make essentially the same point. You have to be careful, when you encourage home dialysis that other factors are in place, such as the right home setting, that the patient understands psychologically. There are other things, not just the economic consideration.

Senator TALMADGE. Thank you very much for your statement.

[The prepared statement of Mr. Tresnowski follows:]

STATEMENT OF THE BLUE CROSS ASSOCIATION, BY BERNARD R. TRESNOWSKI,
EXECUTIVE VICE PRESIDENT

EXECUTIVE SUMMARY

The symptoms and causes of current problems in the delivery of health care services are many and complex. Clearly, the right incentives are not now in place for health care providers alone to effectively eliminate these problems. The development of solutions requires the meaningful participation of Federal and State government, private third-party payors, providers, labor and business. The solutions also involve the integration of several tools: planning, utilization review, payment incentives and systems, alternative and competing systems of financing and delivery of care, and improved health care benefits.

It will take some time for these tools to be designed and interested. In the meanwhile, there is a serious economic problem with respect to hospital and health care costs. That problem needs immediate attention. The challenge is how to ensure some economic relief over the short term, while at the same time stimulating longer term cost containment efforts.

To accomplish this, we recommend a program to be enacted now consisting of two components: (1) a national moratorium on new plant capital expenditures, to be followed by a more permanent capital limitation program, and (2) a program to limit hospital inpatient revenues.

Health care planning, we believe, represents the most critical element in more permanent and effective containment of health care costs. An immediate moratorium on new plant capital expenditures would provide an opportunity to improve the capacity of health planning agencies at State and local levels. It is from these levels that the most effective health planning must begin—as Congress recognized in Public Law 93-641.

A national moratorium on new plant capital expenditures would also help to prevent unnecessary and inefficient movement of equipment and services away from hospitals which would be subject to the revenue limitation program.

Key features in the design of a capital expenditures limitation program—whether a short term moratorium or a permanent program—include (1) incentives to reduce or eliminate excess operating capacity (2) applicability to virtually all Medicare Part A and Part B providers, (3) enforcement in all States primarily through Section 1122 of the Social Security Act, and (4) meaningful local and State level involvement in the development of standards and specific capital expenditure limits.

An interim national program to limit hospital acute care revenues must be simply designed with limited exceptions which focus on equity to consumers and providers. An interim program should also allow the designation of a specific termination point after a more permanent program is in place and effective.

With regard to exemptions from the program, we believe voluntary arrangements on less than a statewide basis should be included. These arrangements would be required to achieve results equal to, or better than, the national program. Exemption opportunities should also be provided for prospective or other incentive payment approaches which promote more effective use of services.

ADDITIONAL COMMENTS ON S. 1470—"ALTERNATIVE APPROACH TO HOSPITAL COST CONTAINMENT"

We are pleased that this revenue limitation program can start soon and will apply to all hospital inpatient care and to all payors. Although we have not calculated precisely the impact of each of the separate elements, we surmise that if general hospital prices were to rise by 6 percent, the revenue limit per day could rise between 10 and 13 percent. With greater utilization, total expenditures for hospital care could be greater.

The proposal does provide an opportunity to reduce total expenditures by reducing the allowable limit for routine operating costs from 20 percent above the peer group average in the first year, depending on the rate of escalation of hospital input prices. If this aspect of the approach were combined with features that limit the rate of increase in the average itself, and both features were tied into utilization control on admissions and days of care, the total effect could be significantly lower rates of expansion in expenditures for hospital care.

We are concerned that the proposed excise tax can become an indirect tax on those who paid premiums for hospital insurance (to the extent of the overpayments) and on the non-insured. This is because any excise tax collected would go to the U.S. Treasury, not to patients or their payors.

OTHER COMMENTS

Further detailed recommendations are made in the full statement concerning aspects of S. 1391 as reported by the the Senate Committee on Human Resources, S. 1470 and the "Alternative Approach," and H.R. 8423—dealing with the End Stage Renal Disease Program.

Mr. Chairman and Members of the Committee, I am Bernard Tresnowski, Executive Vice President of the Blue Cross Association, the national coordinating agency of the 70 member Blue Cross Plans in the United States and Puerto Rico.

I thank you for the opportunity to share with you our thoughts on what must be done over both the short and longer terms to help contain health care costs and on certain specific legislative proposals developed to achieve that objective.

The views I shall present reflect the knowledge and experience gained by the Blue Cross organization through the administration of both public and private health care financing programs.

Based on that experience, we offer the following observations concerning the size and causes of health care cost problems, and the directions the public and private sectors need to go to resolve them.

The symptoms and causes of current problems in the delivery of health care services are many and complex. Medical technology is often widely introduced into the system without careful evaluation of its value and cost-effectiveness in comparison with alternative techniques. There is unnecessary and costly duplication of expensive facilities, equipment and services by health care providers in many communities. There are wide disparities in the patterns and rates of hospital admissions and other service use from community to community with no identified differences in final results. And significant variations can be seen among hospitals of like size and nature in terms of internal productivity.

Clearly, the right incentives are not in place for health care providers alone to effectively eliminate those problems. Our hopes for the future in identifying, testing and using effective incentives rest on the shoulders of a variety of participants—federal and state government, private third-party payors, health care providers themselves, and labor and business. While we have not yet identified the incentive structure that will work, it is increasingly clear that it must include several well integrated and mutually supportive elements: improved health care planning and utilization review programs; better financial incentives in provider rate-setting or payment systems that complement health planning and UR initiatives and promote better day-to-day provider efficiency; alternative, competing systems of financing and delivering health care services such as HMOs or hospital-only capitation payment systems; and improved health care benefits in such areas as home care and second-opinion surgery to promote care in the least costly but medically appropriate setting.

While it will take some time, give the current state of knowledge, for those cost-containment tools to be well designed, effectively integrated and put to work on a broad scale, there is a serious economic problem with respect to health care costs generally, and hospital costs specifically, that needs immediate attention. The challenge is how to ensure some economic relief over the short term, while stimulating, or at least not inhibiting, improvement in the design and operation of cost-containment or incentive mechanisms which have potential for longer term, more permanent and more effective containment of health care costs. There is a tendency to look for simple, permanent solutions now—such as state regulation of hospital rates or major, longer term reforms in Medicare and Medicaid reimbursement. But without enough experience with any single approach, its broad application might not only fail to solve the problem, but could make it worse.

To provide some immediate relief, without inhibiting the movement toward permanent and effective reforms, we recommend a program to be enacted now consisting of two components: (1) a national moratorium on new plant capital expenditures, to be followed by a more permanent capital limitation program; and (2) a program to limit hospital inpatient revenues.

Health care planning—if effective at the institutional, community and state levels—represents the most critical element in more permanent and effective containment of health care costs. Plant capital decisions are major factors in annual operating costs. However, most health care planning is not now effective, primarily for two reasons. First, many health care planning agencies at the state and local level are new, and have not had enough time to develop well-thought-out health care plans or to create workable procedures. Second, the system of health care planning that is emerging under P.L. 93-641 has no provision for plant capital limits to be established at the state or local levels. At these levels health care service needs and the capital projects to meet them can be listed and handled in the order of their importance. A system of health care planning cannot succeed if it only identified needs, but does not determine which are needed first, which are affordable and which are not.

To be effective, the authority and responsibility for establishing realistic capital budget constraints, as well as any related standards for health care

service capacity and use, should rest primarily with state and local planning agencies. That is especially true over the next few years. We believe it would not be effective or practical for the federal government to impose new rules upon state or local health care planning agencies—either strict capital dollar limits or strict supply and use standards for health care plan development or review. Such budgeting limits and standards must be permitted to evolve logically at the local and state level within broad federal guidelines—such as the sound “bottom-to-top” planning that Congress wrote into Public Law 93-641.

An immediate moratorium on new plant capital expenditures would give state and local health care planning agencies some breathing space not only to develop good plans and generally gear-up for effective review of project proposals, but also to establish a type of capital limit that is needed. Also, if broadly applied to various types of health care providers, a moratorium would also help to prevent unnecessary and inefficient movement of equipment and services away from hospitals that would be subject to revenue limitation.

A moratorium program should include tight criteria, and allow only capital projects which are already obligated, are specifically directed at eliminating excess operating capacity, or are aimed at correcting life and safety hazards associated with needed health care facilities or services. Also, the moratorium should apply to virtually all Medicare Part A and Part B providers. Enforcement of the moratorium should be primarily through Section 1122 of the Social Security Act, extended to all states whether or not they have a designated planning agency agreement with the Secretary of HEW. The moratorium should cease to apply in a particular state when the State Health Planning Agency is fully designated by the Secretary and meets all existing requirements of P.L. 93-641, as well as the new capital limit program.

Under both a moratorium and long-term capital limit program, ways need to be found to create financial incentives for health care providers to reduce or eliminate excess operating capacity. This could mean closing or converting portions of a hospital where appropriate fixed costs need to be recognized by all payors. A federal and private grant and reimbursement program may be needed to defray certain fixed costs, such as long-term debt retirement and severance pay for employees, associated with closures or conversions. In addition, a long-term capital limit program administered by a fully designated State Health Planning and Development Agency should allow appropriate increases in a state's dollar limit where capacity is eliminated.

An interim national program to limit hospital acute care revenues must be simply designed with limited exceptions. We would also note that there is very little operational experience to help design and implement a revenue limitation program that is equitable to both hospitals and consumers; and that is administratively simple and effective. An arbitrary revenue limitation program poses certain dangers to the effective delivery of health services. For these reasons, the interim program should allow for exemptions and designation of a specific termination point after a more permanent program is in place and effective.

We believe there must be exemptions from the federal revenue limitation for programs developed by clusters of hospitals working with third party payers that guarantee results. The results would be either:

- (1) a guarantee that a group of hospitals in the exempt program combined would not exceed the increase limitation requirements (including exceptions and pass-throughs) of the national program; or

- (2) a guarantee by a group of hospitals in a defined area that their program for cost containment would:

- (a) change the structure (through introduction of utilization review programs, innovative reimbursement techniques, mergers of hospitals, consolidation of hospital services, etc.) of the health care delivery system, or some part of it in their area; and

- (b) contain the rate of increase in costs of participating hospitals to a level below that which prevailed previously for those hospitals.

It would be especially important to provide exemption opportunities for prospective or other incentive payment approaches which by their very design promote more effective use of services and integration of health care programs among individual institutions serving overlapping areas. HMO or hospital capitation payment programs, or “maxi-cap” approaches such as the one in Rhode Island and the one under development in Rochester, New York, are examples of what we mean.

With those observations as background, I will now comment specifically on S. 1391 as reported by the Senate Committee on Human Resources, and on the expanded version of the hospital cost provisions in S. 1470. I do not intend to comment specifically on S. 1391 as originally introduced by the Administration. For our evaluation of that Bill, I refer you to the Blue Cross Association's testimony of May 26, 1977, presented to the Subcommittee on Health and Scientific Research of the Senate Committee on Human Resources. We also offer comments on the proposals to improve the End Stage Renal Disease Program in H.R. 8423.

S. 1391—TITLE I

Studies, reports

We support the provisions of S. 1391 for special studies to improve the necessary technical tools for an effective revenue limitation program. These developments include a system for classifying hospitals which will reflect both efficiency and services provided. The cost containment program should meet the needs of individual hospitals and should be revised as better tools become available.

We believe that if we had a peer grouping system that validly identified relative efficiency, and we used incentives to encourage change, the impact on cost containment that would be achieved voluntarily would be as great as the results that would be achieved by legislation.

Exemptions

We are disappointed that the revised S. 1391 does not exempt voluntary arrangements on less than a statewide basis from revenue limitations (except as an experiment). These voluntary arrangements could be designed to achieve cost containment and improve the efficiency of health care delivery. As we have said, no one cost containment method has yet proven to be better than any other. Different arrangements should be encouraged and should not be limited to experiments or statewide groupings of hospitals.

Where any program has been exempted, the revenue limit should be equal to the actual rate of revenue limitation achieved nationally after the effects of exceptions have been included in the national computations. For exempt state programs, the present limit of 110 percent of the basic inpatient hospital revenue increase may not fully account for exceptions that would have been allowed under the national program.

Arrangements permitted by experiments should be allowed to continue as long as their performance meets the agreed standards. There is an obvious lack of incentive if participants know that programs will be revoked no matter how successful they are.

S. 1391 should be revised to provide hospitals and third-party payors within the exempted state an opportunity to experiment in hospital reimbursement whenever these voluntary arrangements promise at least equally effective cost containment.

Voluntary arrangements for groups of hospitals should receive the same financial support as S. 1391 provides for statewide arrangements. Restricting financial support to statewide arrangements might reduce the opportunity for the development of alternative arrangements that could be more effective and more equitable.

We are pleased that S. 1391 recognizes the importance of limits on the basis of class of purchaser, and that it is the intent of the exemption provisions for State programs to discourage the shifting of costs among classes of purchasers. That would assure each payor group appropriate protection under the exemption program and minimize inappropriate shifts among payors.

Coverage

The original S. 1391 has been improved by exempting small hospitals from the limit program. That will ease administration without severely limiting the potential for the containment of costs.

All hospitals, including smaller ones, should have to report information required by the revenue limitation program. Information from smaller hospitals is needed to see the effects of their exclusion and to evaluate the overall program.

Volume load formula

The revised formula for adjustment of volume is an improvement over the original proposal. The inclusion of days of care with admissions makes the definition of volume more sensitive to actual changes, and adds incentives to reduce

volume and lengths of stay below the base period. With the exclusion of smaller hospitals, a single system of adjustment (corridors) for all covered hospitals is appropriate. However, if smaller hospitals in SMSAs are included, a two-tier adjustment formula (corridor) needs to be reconsidered.

We are pleased that the Secretary is asked to develop a better formula to adjust revenues for different levels of volume. Marginal costs for declines in volume are likely to be different from marginal costs for increases. Different interpretations have been expressed about how to compute the volume adjustment. Perhaps a series of examples could be included in the Committee report to make the process better understood. One example should clarify that the wage pass-through is subject to the volume load adjustment.

Increase limit definition

We are pleased that the bill provides for the development of a price index based on hospital inputs. This index would be substituted for the general price deflator in the later years of the cost containment program. The hospital price index should more correctly reflect the mix of hospital inputs, which may be quite different from factors contained in the general price deflator.

Disclosure

Financial disclosure can also be a useful way to inform both the public and program administrators. However, we question the need for all the detail requested, including information from all hospitals on capital, surplus, reserves, depreciation, ownership interests, owners of mortgages, principal suppliers associated with financial management or capital sources, and salaries of principal officers.

Exceptions

We continue to question the use of a financial solvency ratio as a necessary condition for an exception consideration. As a measurement, it is not as objective as it may appear. The current asset ratio can vary during a year and over time, and does not adequately reflect long-term financial needs. The use of such a ratio may encourage hospitals to shift financing from long-term to short-term debt without necessarily improving hospital financial administration. The ratio can be manipulated and is not as indicative of need as, for example, negative operating margins.

Wage pass-throughs

We are concerned that the mandatory wage pass-through may result in greater wage increases than otherwise would occur. Furthermore, S. 1391 provides no limits on the amount of the increase that can be passed through. This is not consistent with the overall emphasis of S. 1391 on cost containment. A better solution would be one in which the Congress set forth criteria or guidelines for the Secretary to use in considering requests for case-by-case exceptions.

Hospital revenue base adjustments

We note that the provisions of Section 114(c) are inconsistent with Section 114(b). Section 114(b) provides that the hospital revenue base be adjusted for services discontinued voluntarily, while 114(c) provides that the hospital revenue base not be adjusted for services that the planning agency considers inappropriate (and which should not have been provided).

It would seem more equitable to adjust base period revenues for both situations.

Definitions

The definitions for class of purchaser do not conform to current third-party arrangements. We believe the following categories would simplify administration and further reduce the potential for shifts of payment liability among payor groups:

- Contract payors (charge-based or cost-based, including Medicare);
- Other cost-based payors (e.g., state Medicaid programs);
- Non-contract charge payors.

S. 1391—TITLE II

Temporary moratorium program

Generally, we support the proposed moratorium's comprehensive coverage of new capital expenditures by health service providers. However, we believe the proposed exception categories should be substantially narrowed to announce

a shift in public policy relative to health system capital financing. Accordingly, we recommend that the moratorium except only capital expenditure projects: obligated (through a binding purchase or construction contract) before the moratorium enactment date;
for the elimination of excess capacity, the substitution of less costly outpatient services for inpatient services, or the implementation of cost-effective management techniques;
to correct imminent safety hazards or emergency situations, as determined by the appropriate state agency; or
that are non-equipment related in the non-institutional sector.

Also, we disagree with the proposed exemption of federal hospitals from the proposed moratorium (and the longer term capital limit program). Federal ownership of a hospital does not, we believe, justify its exemption from a program designed to achieve an efficient allocation of capital resources.

We recommend that the proposed capital expenditure review threshold for equipment-related expenditures be changed to cover expenditures greater than \$150,000. The threshold as currently proposed would require an administratively burdensome monitor and review process (to determine aggregate expenditures). Coverage of capital expenditures of \$150,000 or more for units of equipment would, we believe, effectively control the major types of equipment (e.g., CT Scanners).

The moratorium and the exceptions should be administered in each state by the State Health Planning and Development Agency under mandatory Section 1122 review authority. Mandatory extension of the Section 1122 review program to all states is necessary to assure consistent implementation of the moratorium in all states.

Finally, rather than penalizing moratorium violators through fines, we recommend a prohibition of third party payor reimbursement for the capital and operating costs associated with unapproved expenditures, and federal court injunctions or loss of provider participation in the Medicare and Medicaid programs.

Longer term capital limit program

The proposed longer term capital limit program would apply only to hospital capital expenditures, potentially leading to "unbundling" of hospital services. To insure equity and effectiveness, the longer term program should address the capital expenditures of moratorium-covered types of providers. Also the proposed national hospital capital limit of \$2.5 billion currently presumes federal knowledge of the capital resources requirements of hospitals and fails to take into consideration the potential spending effects of the moratorium exception provisions.

In order to support effective local and state level planning, we recommend that each state be required to develop a capital limit program as a condition for full State Agency designation under Public Law 93-641, without imposition at the outset of a fixed national capital expenditure limit. Such state programs could, for example, initially establish an annual capital spending limit below average capital expenditures for covered providers in the three years preceding the moratorium, adjusted for inflation. Subsequent to the implementation of capital limit programs in a majority of the states, the Secretary might then be granted the authority to establish a national capital expenditure ceiling, based on consideration of the capital expenditures proposed by the states. In this way, local and state level planning agencies would have input into the establishment of a national capital spending ceiling. Similarly, we urge that the federal government not impose now specific capacity and use standards upon local and state health planning processes. Such standards should be permitted to evolve based on state and local experiences and input.

Finally, the development of a state Medical Facilities Plan should not be a capital limit program requirement since such a plan is, as specified in law, geared to the allocation of Title XVI funds. Rather, we recommend that the Planning Act be amended to require that Health Systems Plans (HSPs) and State Health Plans (SHPs) set forth prioritized listings of specific service needs, including an estimate of the capital and operating costs associated with the provision of these services.

Excess capacity

Under both the moratorium and longer term capital limit program, there are several provisions directed at the elimination of existing excess service capacity, as identified through the appropriateness review process required by Public Law

93-641. Generally, we find that the proposed reimbursement and state legal penalties which are linked to appropriateness reviews represent, in fact, a proposed national decertification program. We do not agree with such an approach, at this time, since it ignores a variety of complex socio-economic and legal issues.

Specifically, there is a proposed requirement that federally approved CON programs provide that any institutional health service found to be inappropriate be considered as through it had been denied a certificate of need. We believe that this requirement invites provider resistance through both legal and political actions, given the nature of CON enforcement mechanisms which range from fines to court injunction and loss of licensure. Further, the proposed Section 1122 reimbursement penalty for inappropriate services of ten times expenses related to the service is apt to result in local provider solvency problems, rather than constructive elimination of excess capacity. If the decertification concept is to be pursued, we would recommend it be tried and carefully evaluated on a demonstration basis in a few selected states, rather than required for widespread adoption at this time.

Also, the proposed federal grant program allows grant-making after—rather than before—discontinuation of an inappropriate service. Reasonableness dictates that such grants should be available prior to discontinuance of the service in order to effectively encourage such change. Further priorities for grant-making based on the expected cost-savings from eliminated capacity should be required, i.e., grant requests to finance elimination of entire facilities or mergers between or among facilities should receive priority over those for minor facility reduction. Also, such grants should cover all appropriate “fixed costs” of excess capacity elimination, including debt retirement and severance pay, net of the value of assets associated with the discontinued service.

Finally, we recommend that an additional positive incentive for excess capacity elimination be included through the requirement that all payers reimburse institutions their appropriate share of appropriate fixed costs associated with the conversion, merger or partial closing of individual institutions.

S. 1470

Our comments on the revised S. 1470 are based on the document entitled “Alternative Approach to Hospital Cost Containment.” We are pleased that the “Alternative Approach” describes a revenue limitation program that can start soon and will apply to all hospital inpatient care and to all payors. Overall, the proposed program is feasible.

The “Alternative Approach” indicates that each hospital would have its own limit based on the sum of the following:

Routine operating costs (as defined) per day of care, times number of days of care. (Routine operating costs per day may equal but not exceed 20 percent of the peer group average.)

Cost of particular items excluded from routine operating costs (because they are highly variable and may rise faster than other costs).

Ancillary revenues (plus costs after base period) times the number of admissions.

3 percent adjustment for certain costs elements calculated above.

We have not precisely calculated the impact of these separate elements. We surmise, however, that if general hospital prices were to rise by 6 percent, the revenue limit per bed day, assuming no change in number of days of care or number of admissions, could rise between 10 and 13 percent. With greater utilization, total expenditures for hospital care could be greater.

A good case can be made for a pass-through of certain items of operating costs beyond the control of the individual hospital. In selecting these items of cost, it is important to retain the hospital's incentive to minimize these costs and not encourage suppliers and personnel included in a pass-through to leverage the hospital. For example, hospitals need incentives to promote energy conservation. And malpractice insurance costs have shown reductions as a result of risk management and quality control practices.

Also, a fixed allowance per admission for ancillary services offers an incentive to increase total patient expenditures by promoting pre-admission work-ups and other outpatient activity that can be billed separately with no reduction in allowable inpatient revenue.

Reimbursement of routine operating costs on the basis of number of days of care also offer an incentive for increased utilization. These incentives for more

hospital care tend to work against the effectiveness of utilization control procedures.

The suggested approach would also require additional administrative costs because of the need for more records and more audit procedures. For the hospital and for the administration of the program, these elements include:

- allocation of costs by wage and non-wage elements by type of service;
- separation of costs for ancillary services, inpatient and outpatient separately, by wage and non-wage elements;
- allocation of overhead costs for wage and non-wage elements for—
 - routine,
 - ancillary, and
 - excluded items of high variability.

The proposal does provide an opportunity to reduce total expenditures by reducing the allowable limit for routine operating costs from 20 percent above the average of the peer group in the first year to something less than 20 percent, depending on the rate of escalation of hospital input prices. If past rates of price increase were to prevail in the future, the allowable limit above the peer group might be reduced to 10 percent above the average in 10 years.

If this aspect of the approach were combined with features that limit the rate of increase in the average itself, and both features were tied into utilization control on admission and days of care, the total effect could be significantly lower rates of expansion in expenditures for hospital care.

The proposed volume adjustment appears to indicate that a decline of admission volume of 10 percent would result in a decline in the ancillary revenue limit of 10 percent. However, in the proposal example, a decrease in admission volume of 20 percent would reduce the ancillary limit by 25 percent. Fixed costs in the delivery of ancillary services do not appear to be considered, and a penalty is imposed on a hospital for a large decline in the volume of admission.

Of special note, under the "Alternative Approach," it appears that the cost of care covered by federal reimbursement will have more restrictions than cost for all other payors. With a maximum limit set for all payors combined, this federal advantage implies a possible shift in costs towards other payors.

Administrative considerations

Classification of hospitals on the basis of efficiency, with due regard to patient case mix and referral characteristics of hospitals in the community, is a desirable feature of a hospital cost control program. We urge that the Secretary be asked to develop an equitable system of classification that will reflect differences in relative efficiency. Under an appropriate grouping, there would be less likelihood that a hospital would be penalized unfairly. The development of efficiency comparisons would help the industry to improve itself voluntarily.

The penalty proposed in the "Alternative Approach" for routine operating costs over the peer group allowable limit is severe. The penalty for routine operating costs over the limit should not be set back to the average.

In determining average group costs and the allowable limit, final determination of actual costs, which is based on Medicare cost reports, may not occur until 15 months (or more) after the close of a fiscal year. A hospital may be subject to penalties and not know it for a year; or it may question the validity of an assessed penalty for a considerable period after the close of its fiscal year.

Allowable adjustments for hospital wage differentials within a community as permitted by the "Alternative Approach" may need further elaboration and identification of acceptable data sources.

We believe that the amount of time required to process requests for exceptions may exceed the 45 days allowed for cases requiring adverse action by the Secretary.

The excise tax arrangements have several features that deserve more attention. We have mentioned the invitation to the hospitals to exceed the revenue limit by 2 percent. Any excise tax collected would go to the U.S. Treasury, not to the patients or their payors. Thus, the excise tax can be an indirect tax on those who paid premiums for hospital insurance (to the extent of the overpayments) and on the non-insured.

The purpose of H.R. 8423 is to make improvements to the End Stage Renal Disease Program. The Blue Cross Association supports this purpose. The bill offers incentives to both patients and facilities by extending entitlements and

improving the scope of coverage for those patients who elect home dialysis or transplantation—the two most cost-effective modes of treatment for end stage renal disease.

While the bill takes significant steps in eliminating the patient and facility financial disincentives currently in the way of home dialysis and transplantation, certain Program inequities are created against those patients not suited for home dialysis or transplantation. Also, we have no assurance that the desired increase in home dialysis will actually occur or be sustained. In order to limit the financial liability of the ESRD patient, we recommend that all patients be granted entitlement to Medicare with the onset of a regular course of dialysis. We also recommend that the patients hospitalized in anticipation of a transplant be granted entitlement whether or not the transplant in fact occurs.

While the Blue Cross Association supports delivery of health care in the most efficient and economical manner, the decision to dialyze in the home or to accept transplantation should be based on medical, social and psychological judgments and not on economic reasons only. The offering of financial incentives for one course of treatment or another could inappropriately bias the decision regarding a course of treatment. What is of importance to the program is that:

1. financial disincentives are removed from one course of treatment over another,
2. the treatment of patients be regularly monitored by the Renal Network team responsible for delivery of care in their area, and
3. patients and their families be fully educated and informed of the possibilities under the program.

We feel that it is also important to increase efforts to encourage the donation of kidneys through public education, to improve efforts in the proper harvesting of kidneys, and to increase funding for research into the disease itself, and into improved technological development regarding the treatment of the disease. It is in these last areas that perhaps the most significant cost saving gains can be made.

We appreciate the opportunity to present our views on this important matter.

Senator TALMADGE. The next witness is Mr. Michael D. Bromberg, director, national offices, Federation of American Hospitals accompanied by Andrew W. Miller, president-elect and vice president, Hospital Corp. of America.

Mr. Bromberg, you may insert your full statement in the record and summarize it briefly if you will.

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES, FEDERATION OF AMERICAN HOSPITALS, ACCOMPANIED BY ANDREW W. MILLER, PRESIDENT-ELECT AND VICE PRESIDENT, HOSPITAL CORPORATION OF AMERICA

Mr. BROMBERG. Mr. Chairman, we will divide this summary, with your permission.

I am Michael Bromberg, national director of the federation. With me today is Andrew Miller, president-elect of our association and also vice president for operations of the Hospital Corporation of America, the world's largest hospital management companies, owning and managing over 92 hospitals.

With respect to the legislation pending before this committee, particularly that reported by the Senate Human Resources Committee, Mr. Chairman, we would point out that controllable costs in a hospital—wages, administrative, and hotel services—have been increasing at a much slower rate than those over which the hospital has little or no control—medical services, drugs, intensity of care, malpractice insurance, costs of regulation, and patient mix. It is therefore ironic to us that S. 1391 would place a stricter ceiling on the noncontrollable

cost of the hospital and pass through high wage increases for non-supervisory personnel, one area in which management can play a role.

A ceiling on revenues is both price controls on a single industry and it is rationing the services. It is nothing more than a more stringent version of the phase IV price control program rejected by a prior Congress for sound economic, social and medical reasons which remain valid today.

Community health needs, in our opinion, cannot be determined in advance by a Government-mandated dollar ceiling. Rationing can be forced through that approach, but if Congress adopts that method of resource allocation, it will be telling the American people that our values have changed from assuring that community health needs are met to reducing medical advances to a level set by the Federal Government based on the advice of economists instead of community representatives, consumers, or health professionals.

S. 1391 authorizes the Secretary of HEW to establish annual ceilings on all capital expenditures by hospitals up to a maximum annual limit of \$2.5 billion. This dramatic decrease in the availability of capital—a 50-percent reduction in current spending—amounts to a dangerous rationing of medical technology, hospital beds, and quality of patient care.

By giving such a vast new authority to the Secretary, including the power to set annual capital limits for each State, Congress would be changing its basic comprehensive health planning policy set forth just a few years ago in Public Law 93-461. That law places at the State and local level the authority and responsibility for determining community health needs. S. 1391 would replace that policy with arbitrary Federal ceilings based on simple dollar limits and bed or occupancy formulas. In addition, the moratorium and decertification provisions of S. 1391 raise serious constitutional questions, including Government taking of property rights without due process.

Turning to S. 1470, in contrast with the administration proposal, the medicare-medicaid reimbursement reform bill, introduced by Senator Talmadge, represents a major step forward in making those programs more cost efficient. It is an innovative, imaginative plan reflecting an examination of both cause and effect as a necessary adjunct to proposed solutions. The measure correctly presupposes that incentive-based competition—not self-defeating caps—is essential to alleviate escalating costs in the health sector.

Our specific recommendations for modifying S. 1470 are set forth in our testimony of June 8, 1977, before this subcommittee.

Our primary recommendation for containing inflation in the health industry is to employ meaningful economic incentives to encourage the private sector to improve efficiency. Over the past several years we have supported the efforts of the chairman and subcommittee staff to develop medicare and medicaid program reforms in institutional reimbursement and we remain supportive of the incentive provisions of S. 1470.

The underlying causes of hospital cost increases are general inflation in the cost of goods and services purchased by hospitals, advanced medical technology, lack of economic incentives for efficient management, lack of price competition and unrestrained demand. S. 1391 addresses none of these causes, but instead slaps an arbitrary ceiling

on revenues. In fact, it rewards the inefficient provider by allowing higher cost hospitals a greater dollar increase in revenues than lower cost facilities.

The choice between the Government caps and controls embodied in S. 1391 and incentives for private sector efficiencies contained in S. 1470 is a clear choice between opposite remedies for the problem of rising hospital costs. That is why we cannot support the suggested expansion of S. 1470 to cover non-medicaid-medicare revenues through caps on revenues from private sector payors.

The specifications for expanding S. 1470, while less drastic than S. 1391, present the same difficulties and inequities. Ceilings on ancillary service revenues per admission absent any incentives for efficiency would once again cause the ceiling to become the floor, penalize those who have been efficient in the past, be ineffective as a cap if appropriate exceptions for intensity are granted, and cause confusion and additional expense for hospitals attempting to comply with complicated new controls. All of these defects were pointed out earlier this year by the subcommittee chairman in his comments on the administration's original proposal.

We are convinced that S. 1470, as presently drafted, offers the best legislative hope for moderating cost increases without harming the quality of hospital care. We also believe that if medicare-medicaid reimbursement reforms are effective, then private charges and revenue increases will be contained automatically since overall hospital revenues and costs bear a close relationship.

Your constituents—the general public—seem to understand both the need for cost containment and the danger of Government controls. In a recent poll conducted for our association by Louis Harris & Associates, Inc., the public expressed itself in favor of holding down hospital costs, but at the same time by a 3-to-1 margin agreed that Government price controls without controls on wages and supply costs are unfair and by a similar margin opted for local community control rather than Federal or State controls. That same poll showed equal public support for the chairman's original bill as for the administration's ceiling approach.

Mr. Miller will briefly summarize the recommendations.

Mr. MILLER. Mr. Chairman, in prior testimony, the federation has urged adoption of prospective rates or incentive reimbursement under medicare and medicaid combined with review of excessive private rate increases.

With regard to nongovernment patients, we recommend use of the President's general economic policy of "jawboning" of hospital rate increases in excess of an agreed-upon percentage. The threat of adverse publicity from findings of local insurers and the President's Council on Wage-Price Stability would certainly create a climate in which most hospitals would hold down spending increases.

For example, all hospitals seeking charge increases in excess of 80 percent of the hospital service charge component of the CPI could be required to disclose and justify their budgets.

A national guideline for hospital price increases could be established with review of increases above that level by the President's Council on Wage-Price Stability, utilizing publicity as a disincentive to unrestrained price increases.

We also favor a gradual expansion of S. 1470 to include medicare-medicaid incentive reimbursement target rates for ancillary services. This could be done by utilizing the same hospital classification system outlined in S. 1470 for routine costs and determining average costs for ancillary procedures or units of service within each grouping. Standard definitions for each procedure or unit should be developed and reimbursement would be subject to the same incentives and penalties as those for routine costs. Reimbursement would be limited to 120 percent of the average target rate, adjusted for wage and area hospital cost increases. Incentive payments would be made to providers with below average costs.

This methodology is more consistent with the provisions of S. 1470 and would provide additional incentives for cost containment in delivering ancillary services than a ceiling on revenues. We would urge that hospitals with less than 4 full years operating experience be exempt from any cost control bill because of high startup costs.

In addition, we recommend that hospitals owned by the same parent organization—whether public, religious, or private—be allowed to aggregate revenues and file a consolidated report for purposes of complying with any ceiling on revenues.

The subcommittee chairman and staff have shown a desire to bring about reimbursement reform in a fair and equitable manner rather than accept the drastic, hatchet techniques of S. 1391. The American people expect the best medical care in the world. We sincerely believe that S. 1391 would have an adverse impact on the quality of that care by stifling capital necessary for physical plant maintenance and replacement, needed technology advances, and improved services, particularly in rural areas. Hospitals, regardless of ownership or sponsorship, must be well-managed with an adequate surplus of revenues over expenses to maintain quality of services. Some of the proposals contained in the specifications released by the subcommittee prior to these hearings would endanger management's ability to assure these objectives.

While the specifications represent an improvement over the provisions of S. 1391, basic problems of any price control scheme cannot be corrected. We hope the chairman will stand by his original analysis of the weaknesses in S. 1391 and reject the addition of caps to S. 1470 for the same reasons.

Senator TALMADGE. Thank you very much.

Any questions, Senator Dole?

Senator DOLE. I have no questions.

Senator TALMADGE. Thank you for your statement, gentlemen.

[The prepared statement of Mr. Bromberg follows:]

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES, AND ANDREW W. MILLER, PRESIDENT-ELECT, FEDERATION OF AMERICAN HOSPITALS

On behalf of the members of the Federation of American Hospitals, we would like to thank the Subcommittee for this opportunity to present our views on hospital cost containment proposals.

I am Michael D. Bromberg, Director, National Office of the Federation of American Hospitals. Accompanying me is Andrew W. Miller, President-Elect of our organization and Vice President—Operations of Hospital Corporation of America, Inc., the world's largest hospital management companies.

The Federation of American Hospitals is the national association of investor-owned hospitals, an industry with 1,050 hospitals in the United States and over

110,000 beds. In addition, our member hospital management companies now manage under contract approximately 200 additional hospitals, including teaching institutions, public, religious and other community non-profit hospitals.

As tax paying institutions, investor-owned hospitals have been particularly interested in modern professional management of our nation's health facilities.

PROPOSED CEILINGS ON REVENUES AND CAPITAL

Controllable costs in a hospital (wages, administrative, hotel services) have been increasing at a much slower rate than those over which the hospital has little or no control (medical services, drugs, intensity of care, malpractice insurance, costs of regulation and patient mix). It is ironic that S. 1391, legislation under consideration today, would place a stricter ceiling on non-controllable costs of the hospital and pass through high wage increases of non-supervisory personnel.

A ceiling on revenues is price controls on a single industry. It amounts to nothing more than a more stringent version of the Phase IV hospital price control mechanism of the Economic Stabilization Program rejected by a prior Congress for sound economic, social, and medical reasons which remain valid today.

Community health needs cannot be determined in advance by a government-mandated dollar ceiling. Rationing can be forced through that approach, but if Congress adopts that method of resource allocation, it will be telling the American people that our values have changed from assuring that community health needs are met to reducing medical advances to a level set by the federal government based on the advice of economists instead of community representatives, consumers, or health professionals.

S. 1391 authorizes the Secretary of HEW to establish annual ceilings on all capital expenditures by hospitals up to a maximum annual limit of \$2.5 billion. This dramatic decrease in the availability of capital—a 50 percent reduction in current spending—amounts to a dangerous rationing of medical technology, hospital beds, and quality of patient care.

By giving such a vast new authority to the Secretary, including the power to set annual capital limits for each state, Congress would be changing its basic comprehensive health planning policy set forth just a few years ago in Public Law 93-641. That law places at the state and local level the authority and responsibility for determining community health needs. S. 1391 would replace that policy with arbitrary federal ceilings based on simple dollar limits and bed or occupancy formulae. In addition, the moratorium and decertification provisions of S. 1391 raise serious Constitutional questions, including government taking of property rights without due process.

The Federation of American Hospitals supported P.L. 93-641 as a rational vehicle for community based decisions on needed health services. There is no way to make those important decisions by some magic formula or dollar limit. Those issues are best studied and debated at the local level, not left to the discretion of the Secretary of HEW who will be influenced more by federal budget constraints rather than by community health needs.

S. 1470

In contrast with the Administration proposal, the Medicare-Medicaid Reimbursement Reform bill, introduced by Senator Talmadge, represents a major step forward in making those programs more cost efficient. It is an innovative, imaginative plan reflecting an examination of both cause and effect as a necessary adjunct to proposed solutions. The measure correctly presupposes that incentive based competition—not self-defeating caps—is essential to alleviate escalating costs in the health sector.

Our specific recommendations for modifying S. 1470 are set forth in our testimony of June 8, 1977 before this Subcommittee.

COST CONTAINMENT VS. PRICE CONTROLS

Our primary recommendation for containing inflation in the health industry is to employ meaningful economic incentives to encourage the private sector to improve efficiency. Over the past several years we have supported the efforts of the Chairman and Subcommittee staff to develop Medicare and Medicaid pro-

gram reforms in institutional reimbursement and we remain supportive of the incentive provisions of S. 1470.

The Federation has on the other hand opposed the Administration proposal for drastic revenue and capital controls. S. 1391, as approved by the Senate Committee on Human Resources, establishes a federal wage and price control system which is complicated, arbitrary, and inequitable. That proposal contains no real incentives for efficiency and would simply repeat all the mistakes made by those who led us into Phases I through IV of the Economic Stabilization Program earlier in this decade. Price controls are by their very nature arbitrary and unfair to individual providers and to the public which would feel the adverse impact on the quality of services delivered under such a system.

The underlying causes of hospital cost increases are general inflation in the cost of goods and services purchased by hospitals, advanced medical technology, lack of economic incentives for efficient management, lack of price competition and unrestrained demand. S. 1391 addresses none of these causes, but instead slaps an arbitrary ceiling on revenues. In fact, it rewards the inefficient provider by allowing higher cost hospitals a greater dollar increase in revenues than lower cost facilities.

That approach would be a signal to hospital management to raise prices to the maximum level and it would penalize those who exercised price restraint in the past by imposing the same ceiling on their lower based period revenues.

The choice between the government caps and controls embodied in S. 1391 and incentives for private sector efficiencies contained in S. 1470 is a clear choice between opposite remedies for the problem of rising hospital costs. That is why we cannot support the suggested expansion of S. 1470 to cover non-Medicare-Medicaid revenues through caps on revenues from private sector payors.

PROPOSED EXPANSION OF S. 1470

The specifications for expanding S. 1470, while less drastic than S. 1391, present the same difficulties and inequities. Ceilings on ancillary service revenues per admission absent any incentives for efficiency would once again cause the ceiling to become the floor, penalize those who have been efficient in the past, be ineffective as a cap if appropriate exceptions for intensity are granted, and cause confusion and additional expense for hospitals attempting to comply with complicated new controls. All of these defects were pointed out earlier this year by the Subcommittee Chairman in his comments on the Administration's original proposal.

In addition, the specifications for expanding S. 1470 to revenues from ancillary services share these inequities with S. 1391:

- Hospitals have no legal authority to control the volume of services ordered by physicians which a cap on revenues ignores;

- The haste with which the plan is proposed to be implemented ignores the complexities and long-range impact of the issue;

- Hospitals cannot accurately forecast revenues by class of purchaser until year's end;

- The timing ignores basic principles of planning and management;

- An October 1st deadline ignores the necessary administrative personnel in both government and hospital positions; and

- The cost of implementing the proposal has not been calculated; nor has its cost effectiveness been evaluated.

We are convinced that S. 1470, as presently drafted, offers the best legislative hope for moderating cost increases without harming the quality of hospital care. We also believe that if Medicare-Medicaid reimbursement reforms are effective, then private charges and revenue increases will be contained automatically since overall hospital revenues and costs bear a reasonable relationship.

We oppose the expansion of S. 1470 to non-Medicare-Medicaid revenues for the reasons set forth above. With regard to routine services the specifications fail to recognize the long list of non-allowed but legitimate costs incurred by hospitals. Any percentage, such as the three percent proposed in the specifications, added to costs for purposes of determining reasonable charges, should include those non-reimbursed costs under Medicare and Medicaid, such as telephone, television, stock maintenance, and necessary business costs, federal and state income taxes, franchise taxes, and bad debts. In addition, investor-owned institutions require a higher margin than three percent of revenues over expenses in order to assure a fair return to investors.

The difficulties of capping charges by simply adding a percentage to allowable costs are so numerous that we strongly urge this provision be deleted. The appropriate charge structure for a hospital is among the most important management decisions and government interference in that area can only lead to higher costs.

The costs of complying with government controls should be carefully considered by the Subcommittee. Aside from the additional burden on the federal bureaucracy, each hospital would need increased accounting and financial management assistance in determining how to comply with the complicated regulations under a measure such as S. 1391.

The history of government price controls is not a record of achievement. The Medicare and Medicaid programs have themselves been a major cause of inflation and it makes sense to begin reforming those programs. If Congress attempts to control all revenues through drastic price-revenue ceilings, then we predict a grave setback for quality health care and for life saving technology. If the federal government wants to control charges to private patients, then government programs should pay the same rate for services paid by private patients.

Your constituents—the general public—seem to understand both the need for cost containment and the danger of government controls. In a recent poll conducted for our association by Louis Harris & Associates, Inc., the public expressed itself in favor of holding down hospital costs, but at the same time by a three to one margin agreed that government price controls without controls on wages and supply costs are unfair and by a similar margin opted for local community control rather than federal or state controls. That same poll showed equal public support for the Chairman's original bill as for the Administration's ceiling approach.

RECOMMENDATIONS

In prior testimony the Federation has urged adoption of prospective rates or incentive reimbursement under Medicare and Medicaid combined with review of excessive private rate increases.

With regard to non-government patients, we recommend use of the President's general economic policy of 'jawboning' of hospital rate increases in excess of an agreed upon percentage. The threat of adverse publicity from findings of local insurers and the President's Council on Wage-Price Stability would certainly create a climate in which most hospitals would hold down spending increases.

For example, all hospitals seeking charge increases in excess of 80 percent of the hospital service charge component of the CPI could be required to disclose and justify their budgets.

A national guideline for hospital price increases could be established with review of increases above that level by the President's Council on Wage-Price Stability, utilizing publicity as a disincentive to unrestrained price increases.

We also favor a gradual expansion of S. 1470 to include Medicare-Medicaid incentive reimbursement target rates for ancillary services. This could be done by utilizing the same hospital classification system outlined in S. 1470 for routine costs and determining average costs for ancillary procedures or units of service within each grouping. Standard definitions for each procedure or unit should be developed and reimbursement would be subject to the same incentives and penalties as those for routine costs. Reimbursement would be limited to 120 percent of the average target rate, adjusted for wage and area hospital cost increases. Incentive payments would be made to providers with below average costs.

This methodology is more consistent with the provisions of S. 1470 and would provide additional incentives for cost containment in delivering ancillary services than a ceiling on revenues. We would urge that hospitals with less than four full years operating experience be exempt from any cost control bill because of high start-up costs. In addition, we recommend that hospitals owned by the same parent organization—whether public, religious, or private—be allowed to aggregate revenues and file a consolidated report for purposes of complying with any ceiling on revenues.

The Subcommittee Chairman and staff have shown a desire to bring about reimbursement reform in a fair and equitable manner rather than accept the drastic, hatchet techniques of S. 1391. The American people expect the best medical care in the world. We sincerely believe that S. 1391 would have an adverse impact on the quality of that care by stifling capital necessary for physical plant maintenance and replacement, needed technology advances, and improved services, particularly in rural areas. Hospitals, regardless of ownership or spon-

sorship must be well managed with an adequate surplus of revenues over expenses to maintain quality of services. Some of the proposals contained in the specifications released by the Subcommittee prior to these hearings would endanger management's ability to assure these objectives.

While the specifications represent an improvement over the provisions of S. 1391, basic problems of any price control scheme cannot be corrected. We hope the Chairman will stand by his original analysis of the weaknesses in S. 1391 and reject the addition of caps to S. 1470 for the same reasons.

SUMMARY OF RECOMMENDATIONS

In contrast with the Administration proposal, the Medicare-Medicaid Reimbursement Reform bill (S. 1470), introduced by Senator Talmadge, represents a major step forward in making those programs more cost efficient. It is an innovative, imaginative plan reflecting an examination of both cause and effect as a necessary adjunct to proposed solutions. The measure correctly presupposes that incentive based competition—not self-defeating caps—is essential to alleviate escalating costs in the health sector.

The choice between the government price controls embodied in S. 1391 and incentives for private sector efficiencies contained in S. 1470 is a clear choice between opposite remedies for the problem in rising hospital costs. This is why we cannot support the suggested expansion of S. 1470 to cover non-Medicare-Medicaid revenues through caps on revenues from private sector payors.

With regard to nongovernment patients, we recommend use of the President's general economic policy of 'jawboning' of hospital rate increases in excess of an agreed upon percentage.

We also favor a gradual expansion of S. 1470 to include Medicare-Medicaid incentive reimbursement target rates for ancillary services. This could be done by utilizing the same hospital classification system outlined in S. 1470 for routine costs and determining average costs for ancillary procedures or units of service within each grouping.

Senator TALMADGE. The next witness is Dr. Charles B. Womer, immediate past chairman, Council of Teaching Hospitals, Association of American Medical Colleges, and president, University Hospital of Cleveland.

Doctor, we are delighted to have you with us, and you may insert your full statement into the record, and summarize it if you will.

STATEMENT OF CHARLES B. WOMER, IMMEDIATE PAST CHAIRMAN, COUNCIL OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND PRESIDENT, UNIVERSITY HOSPITALS OF CLEVELAND

Mr. WOMER. Thank you, Mr. Chairman. I should correct one thing. I am not a physician.

Before beginning my statement, I would like to note that I am accompanied this morning by Richard Knapp of the association's Department of Teaching Hospitals. Because I believe this subcommittee and its staff are familiar with the AAMC and its Council of Teaching Hospitals, I will, in the interests of time, dispense with the usual formalities. At the outset, the AAMC continues to endorse the positions and observations contained in our June 8th testimony before this subcommittee, and again, in the interests of time, I will avoid repetition of them.

The association is opposed to the administration's cost-containment proposals. We believe that the particular type of nationwide cap on revenues proposed by the administration is unreasonable in the short-term and that it will have highly adverse effects on our Nation's ability

to rationally limit hospital expenditures in the long run. Among other things, the AAMC is also opposed to the administration's proposed permanent and arbitrary limit on hospital capital expenditures and the inflexible ceiling on supply of hospital beds without regard to variations in regional hospitals.

Mr. Chairman, we are in agreement with many of the principles embodied in the outline for an expanded S. 1470. I want to emphasize the word "principles" because the methodologies used to implement principles are important, and as you are aware, the outline that we received a few days ago does not contain important definitions of terms and details that would be necessary for us to comment definitively on a proposal's technical aspects. For example, the definition to be applied to the term "revenue" is extremely important to teaching hospitals. It could be defined in ways that are fair and equitable; however, it could be defined in other ways that would have disastrous effects.

With that caveat, the principles that we are pleased to see embodied in S. 1470 include:

First, the effort made to recognize differences among institutions and geographic regions in the control mechanism.

Second, the effort which is being made to compare costs which should be most similar among institutions and to exclude those costs which are uncontrollable or, for very good reasons, vary widely among institutions.

Third, the recognition that the costs of goods and services purchased by hospitals often vary from the changes in costs in the overall economy and the intention to recognize these differences.

Fourth, the intention to include an enlightened exceptions process and the provisions for increases resulting from changes in patient mix and the intensity of care provided.

Fifth, the recognition of the cumulative effect of year-to-year cost increases.

Sixth, the inclusion of incentives for those hospitals in a group that have below-average costs.

Seventh, the requirement for uniform reporting of hospital costs.

Eighth, recognition that all admission increases have costs associated with them.

Ninth, recognition of the operating costs increases of approved expansion of patient care services. (As an aside, although the outline does not refer to them, we trust that this recognition will be expanded to services introduced during the institutions' base year.)

Tenth, the collective rather than separate application of routine and ancillary revenue ceilings.

Eleventh, the recognition of regional variations in wage levels.

While the association is pleased with the above-mentioned principles for an expanded S. 1470, we are very concerned about one long-range aspect of the outline. If the program were to become operational and efforts to refine the approach continue, we would like to add a word of caution concerning item five of the basic description of the outline. It is stated that as the methodology for cost-reporting and allocation of costs is made more precise, the system of comparing costs to determine reasonableness would be expanded to include all or some ancillary service departments. From the perspective of regulatory complexity and, more important to us, from the standpoint of institutional man-

agement, there is a question of how far one might wish to go in this regard. The deeper one goes in comparing specific revenue and/or ancillary service departments, the more peculiarities of institutional characteristics become important to recognize, but difficult to quantitatively define. Also, I believe that one result of such an approach would be to factionalize the management of the hospital. A hospital is a very complex institution whose many facets need to be carefully coordinated to serve the needs of patients and to accomplish effective cost containment. A hospital control system, which establishes many intrainstitutional ceilings, threatens to undermine this coordination. Therefore, we would advise the subcommittee to proceed very cautiously with this approach.

Some of the other significant concerns that the association has addressed in some detail in its previous testimony, which I will only mention today, include:

One, we previously have expressed concern about the classifications system to be used in grouping hospitals. The expansion of the program to include all costs, revenues and payors heightens our concern in this regard. It is most important that the system be significantly more equitable and sophisticated than that which was used in implementing section 223 of Public Law 92-603, and that it be capable of timely modification, when such is indicated.

Two, the hospital market basket index to be used must be one that reflects cost increases in goods and services purchased by hospitals with considerable precision.

Three, we are concerned that inadequate recognition may be provided for the cost of new ancillary services which do not require capital expenditure approval.

Also, as I mentioned at the beginning of my testimony, the content of a number of details and definitions is extremely important to us. These include the definition of revenue, the treatment of revenues related to exclude routine costs, and the treatment of special care units, such as intensive care and coronary care units.

Mr. Chairman, the Association of American Medical Colleges and its members are willing to work constructively with all parties in Government and with the private sector to develop practical, equitable, and administrable controls which continue to maintain the quality of patient care demanded by the public. We recognize that such a program will be neither easy to create or simple to apply. As Alice Rivlin, Director of the Congressional Office of the Budget has aptly stated:

It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without, at the same time, curtailing desirable improvement in quality of health services and imposing undesirable rigidities on the delivery system will be a sensitive and difficult task.

We commend this subcommittee and its staff for its recognition of this fact, and for your efforts to devise a control program to moderate hospital costs that is not based on overly simplistic solutions to difficult, long-term problems. We recognize that the outline that we have commented upon today is but a step in the subcommittee's efforts to develop an equitable program and that much more difficult work remains to be done. We applaud the seriousness with which you have taken your difficult task and your avoidance of devisive rhetoric and harangue. We look forward to working with you and your subcom-

mittee's able staff in your efforts to develop legislation that is fair, equitable, and in the long-term public interest.

Thank you, Mr. Chairman.

Senator TALMADGE. We appreciate very much your concise and constructive statement.

Any questions, Senator Dole?

Senator DOLE. No.

I was just talking to my staff about ancillary, including ancillary services. I think you have indicated some of the problems and I was trying to confirm what you were saying. I was listening, but I was also conferring.

Mr. WOMER. Thank you, sir.

Senator TALMADGE. Thank you very much.

[The prepared statement of Mr. Womer follows:]

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUMMARY

I. AAMC's general position on hospital cost containment

A. The AAMC and its members are willing to work constructively with all parties in government and the private sector to develop, promote, and advance hospital cost containment programs which are practical, equitable, and administrable and which continue to maintain the quality of patient care demanded by the public.

B. Hospital cost increases are primarily the result of changes in the following cost components:

1. the inflation in the general economy;
2. the imposition of government-mandated programs;
3. the introduction and changing mix of services and technologies;
4. the population's utilization patterns; and
5. the hospital's increasing complexity and its coordination needs.

C. A cost containment program to reduce hospital costs without disrupting necessary health services must be designed with full recognition of the hospital's limited ability to influence or control many of its cost components.

D. The AAMC believes that a six point program based on (1) uniform reporting, (2) published financial data, (3) cost impact statements for new legislation and regulations, (4) fully implemented PSRO and health planning programs, (5) comparative prospective payment ceilings, and (6) Medicare payment of state-determined rates provides an opportunity to commence a national cost containment strategy which will provide an equitable, realistic, and administrable foundation for a longer run cost containment strategy.

II. S. 1391, Title I

A. The AAMC believes that the Administration's proposal of a nationwide cap on revenue is unreasonable in the short-term and that it will have highly adverse effects on our nation's ability to rationally limit hospital expenditures in the long-run.

B. Arbitrary revenue limitations, while administratively easy to impose at the payors level, are inequitable, based upon false assumption of hospital homogeneity, ignore historical trends and recent developments, and do not recognize the inter-relationship of hospital activities. Moreover, by indiscriminately providing highly favorable payments to some hospitals and relatively punitive payments to others, an arbitrary revenue ceiling threatens to disable the hospital industry, to impose irrational and unintended effects, and to create additional residual problems for any long-run containment of hospital costs. Therefore, the AAMC strongly recommends that Title I of S. 1391 not be enacted.

C. In addition to including the problems inherent in an arbitrary nationwide cap on hospital revenues, the Administration's proposal includes the following additional problems:

1. The formula proposed by the Administration for determining revenue increases is based on an inappropriate measure of inflation, misleads those who use a single percentage to describe the proposal's impact, and adds unnecessary complexity at hospital and pay or levels.

2. The Administration's proposal uses a 1976 based year for determining hospital's revenue limitations regardless of the tenure of the cost containment program.

3. The establishment of at least four separate payment categories under the Administration's proposal for determining revenue limitations for Medicare, Medicaid, other cost-based, and charge-based payors does not recognize the payment characteristics of patients or the operational realities of hospitals.

4. The Administration's proposal provides no recognition or adjustment for the impact of patient mix on hospital costs.

5. The exceptions process proposed by the Administration is wholly inadequate.

6. By using gross revenues rather than net revenues, the Administration's proposal could actually reduce hospital revenues below their present levels.

7. The Administration's proposal uses gross revenues because of their computational convenience for hospital payors. However, the use of gross revenues will increase the complexity of hospital operations and add significant uncertainties to revenue projections.

D. S. 1391, as amended and adopted by the Senate Human Resources Committee, retains a cost containment approach based on a fixed percentage cap. In spite of several amendments it retains the inherent weaknesses of that approach, and it includes new provisions introducing significant new shortcomings: a mandatory wage pass through and a civil suit authorization. Therefore, the AAMC is strongly opposed to Title I of S. 1391 as adopted by the Human Resources Committee.

III. S. 1391, Title II

A. The AAMC urges the members of Congress to ask whether it is logical to continue every few years to enact new federal health planning legislation to replace previous statutory programs that failed because they were poorly financed, insufficiently staffed and not given a fair chance to succeed.

B. The AAMC believes that, if the present health planning law is allowed to operate effectively, it will provide the necessary mechanisms to review and determine the need for proposed capital expenditures.

C. The AAMC is strongly opposed to the Administration's proposed permanent and arbitrary limit on hospital capital expenditures, the ceiling on the supply of hospital beds and the standard for occupancy of hospital beds to which short-term acute care hospitals would be subjected.

D. The AAMC urges Congress to refrain from adopting the Human Resources Committee's proposed moratorium and recommends that Title II of S. 1391, as amended, be considered in a comprehensive review of the planning act.

E. The AAMC has supported the strengthening of the health planning program; however the stronger cost containment orientation taken by HEW in the proposed National Guidelines for Health Planning, together with the currently proposed cost containment legislation, S. 1391, would undoubtedly lead to an extremely undesirable situation with regard to the future availability of tertiary care services in this nation. The AAMC requests that that Administration consider the implications discussed and respond to this issue.

IV. S. 1470, as expanded

A. General comments:

1. The AAMC supports uniform hospital cost reporting.

2. The AAMC strongly recommends that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review program progress, monitor program implementation, examine problems encountered and make recommendations regarding appropriate solutions for problems identified.

3. The AAMC recommends that developed legislation include a viable and timely exceptions and appeal process which includes the requirement for action on exceptions in 45 days.

4. The AAMC finds state rate/budget review systems are acceptable where they meet specific organizational and operational characteristics.

5. The AAMC requests clarification of how excluded costs would be included in the proposed revenue ceiling.

B. Routine service revenue:

1. The AAMC reiterates its July, 1977 concerns and recommendations.

2. The AAMC recommends that, in computing adjusted routine service costs, a previous accounting period's allowable costs be used in the calculation without adjustments for incentive payments or reimbursement penalties.
- C. Ancillary service revenues:
 1. The AAMC strongly recommends that a hospital be permitted to use its base year ancillary service expenditures as its base where revenues received were less than actual expenditures.
 2. The AAMC recommends that the evaluation of proposed price indices for ancillary service limits be made by the proposed National Technical Advisory Board.
 3. The AAMC strongly recommends allowing a previously controlled fiscal year to serve as the base period for the present year when adequate operational experience is available.
 4. The AAMC requests clarification of the treatment of special care units—CCUs, ICUs, etc.—under the proposed legislation.
 5. The AAMC requests clarification of the volume adjustment examples.

STATEMENT

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the "Hospital Cost Containment Act of 1977," S. 1391, and on an expanded version of the "Medicare-Medicaid Administrative and Reimbursement Reform Act," S. 1470. In addition to representing all of the Nation's medical schools and 60 academic societies, the Association's Council of Teaching Hospitals includes over 400 of the Nation's major teaching hospitals. These hospitals: account for over sixteen percent of the admissions and approximately 20 percent of the ambulatory care services provided by non-Federal short-term hospitals, provide a comprehensive range of patient services, including the most complex tertiary services, and are responsible for a majority of the Nation's graduate medical education programs. Thus, the proposed hospital revenue limitations and capital expenditure controls and the consequences of these limitations and controls are of direct interest and vital concern to the Association's members.

For ease and clarity of presentation, this testimony is organized in four parts: (1) a statement of the causes of hospital cost increases and the Association's recommendation for containing hospital costs, (2) an evaluation of Title I of S. 1391 as proposed by the Administration and as amended by the Senate Human Resources Committee, (3) a discussion of Title II of S. 1391, and (4) initial reactions to the outline provided for an expanded version of S. 1470 which would cover all hospital payors and all hospital costs.

THE AAMC'S GENERAL POSITION

The problem of hospital expenditures

The AAMC and its members fully appreciate the fact that total national health expenditures have increased from \$12.7 billion, or 4.5 percent of the Gross National Product, in 1950 to \$139.3 billion, or 8.6 percent of the GNP, by 1976 and that aggregate expenditures for hospital care increased from \$3.9 billion in 1950 to \$55.4 billion in 1976. These 27 year expenditure trends are paralleled by the trend for hospital expenses per unit of service. For example, hospital expenses per patient day¹ were \$7.98 in 1950, \$16.46 in 1960, \$118.69 in 1975.

The Association also appreciates the problems that these cost and expenditure trends have created: health insurers have had to seek substantial increases in premiums at frequent intervals, industrial firms and labor unions have had increases in the costs of the health insurance fringe benefits that exceeded the expectations of all negotiating parties, consumers have found premiums for existing coverage rising at the same time that they have needed to increase their coverage limits to obtain adequate protection, and government officials and agencies have seen expenditure increases that have limited the opportunities to initiate new programs or strengthen existing programs. As a result, a national consensus is evolving that there is an urgent need to reduce the rate of increase in health care costs.

¹ The statistic "expenses per patient day" is deficient as a basis for examining cost trends because it treats all hospital days as homogeneous, ignores ambulatory care provided in the hospital, and assumes the hospital product is a constant. Nevertheless, it is used here as an example of the statistical data which have contributed to the public's perception of the problem of hospital costs.

The AAMC recognizes this national concern, and the Association and its members are willing to work constructively with all parties in government and the private sector to develop, promote, and advance hospital cost containment programs which are practical, equitable, and administerable and which continue to maintain the quality of patient care demanded by the public. In order to develop a cost containment program consistent with these characteristics, factors responsible for the present rate of increase in the costs of hospital services must be understood and considered.

Sources of increased hospital costs

Hospital cost increases are primarily the result of changes in the following cost components:

- The inflation in the general economy;
- The imposition of government-mandated programs;
- The introduction and changing mix of services and technologies;
- The population's utilization patterns; and
- The hospital's increasing complexity and its coordination needs.

Hospitals must purchase goods, services, and manpower. General and multi-purpose goods such as food, fuel, utilities, and general liability insurance are purchased from suppliers servicing many industries. In purchasing these goods and services, cost increases for hospitals will be similar to those experienced by the general economy. Hospitals also purchase goods and services of a distinctly medical character. Pharmaceuticals, laboratory supplies and reagents, and malpractice insurance have limited markets; changes in the prices of these goods may be greater or less than the economy's average inflation. Similarly, in recruiting personnel, hospitals compete in markets shared by other industries—such as food service, housekeeping and construction—and in specialized markets—such as those for medical, paramedical, and technical personnel. In each of these labor markets, hospitals have traditionally experienced relatively low wages for their employees; however, as employee and community attitudes have changed in the past decade, hospitals have had to become and remain competitive with the general community in salaries and fringe benefits. For goods, services, and manpower, hospitals now pay a competitive price, and price increases in both general and specialized resource markets must be incorporated into hospitals' changing costs.

Hospitals are subject to government-mandated programs enacted by Federal, State and local governments which increase costs. The hospital must comply with changing building, fire, and life safety codes. Antipollution and solid waste control standards must be attained. Pension reform provisions must be met. Higher Social Security taxes must be funded. Extensive alterations must be undertaken to comply with the handicap regulations recently promulgated by the Secretary of DHEW. Each of these programs, regardless of its social desirability, increases the operating expenses of hospitals without increasing their services.

Hospitals of the mid-seventies are significantly different from those of the early fifties. New and more effective diagnostic and therapeutic modalities are available. Life saving technologies such as intensive care and renal dialysis have been introduced. Standards of medical practice for many diseases have changed in response to new procedures and techniques. Some of these developments have reduced hospital costs by providing comparatively less expensive therapies for previous services; many, however, have increased costs by adding new and complementary capabilities to hospitals. As a result, Social Security Administration findings, shown in Table 1, document that for the past 25 years approximately 50 percent of the total increase in hospital costs has resulted from improvements in hospital services.

The population's use of the hospital is changing. Increasing levels of education and income are accompanied by increasing demands for the most sophisticated and costly hospital services. Emergency rooms and organized outpatient departments are providing complex specialty and ancillary services in addition to primary ambulatory care. Increased numbers of aged citizens with serious acute disorders and severe chronic conditions require increases in the ancillary and nursing support provided by the hospitals. Long-term and self-care facilities organized apart from hospitals are being used for the less expensive recuperating patients, while the complex and expensive patients have remained in hospitals. Each of these changes contributes to increasing hospital unit costs.

TABLE 1.—Average annual percentage increase in hospital costs resulting from improvements in hospital services

Time period:	Average annual percentage increase
1951-60	50.0
1960-65	48.5
1965-67	60.3
1967-69	41.8
1969-71	44.7
1971-73	48.7

SOURCE.—Social Security Administration. Medical Care Expenditures, Prices and Costs: Background Book. September 1975, p. 39.

As a public resource, hospitals are expected to meet the needs of their community. Therefore, hospitals have added new services, equipment, and personnel to meet the public's desire for access to the latest medical and scientific accomplishments. Unfortunately, some duplications of underutilized, but expensive, services have also occurred. As hospitals have increased services and staff, coordination of activities has become more difficult to maintain. Additional reporting and control systems requiring more staff have been developed and implemented to maintain institutional effectiveness. In these respects, hospitals, and their costs, are no different from other industries which have also found it necessary to expand administrative services and, thus, to increase organizational overhead.

A cost containment program to reduce hospital costs without disrupting necessary health services must be designed with full recognition of the hospital's limited ability to influence or control many of its cost components. This is especially true of the inflation level present in the economy and the requirements of government-mandated programs. These cost increase factors are beyond the control of hospitals, individually and collectively.

Also beyond the control of hospitals are the unclear and inconsistent policies and priorities confronting these public service organizations.

For example:

Practitioners are encouraged to "optimize" the use of hospital services to contain costs while large malpractice awards to patients with adverse outcomes encourage practitioners to request more professional consultations and ancillary services and dramatically increase malpractice premiums.

Regionalization of health services, which concentrates expensive services in a few hospitals, is sought while reimbursement programs seek to apply uniform payment levels without recognition of case mix differences.

Health planning regulations for capital expenditures in institutions are undertaken while similar expenditures in physicians' offices are excluded from review and approval.

Free care and below cost care are mandated for public patients while third party payors and consumer groups pressure the hospital to prevent charges from exceeding costs for paying patients.

Certification and licensure are sought and frequently legislated for paraprofessional and technical personnel while hospitals are encouraged to use fewer and more flexible personnel.

Primary care emphasizing ambulatory and preventive services is sought while outpatient clinics lose money and special program funds for catastrophic care are more easily attainable and abundant.

Utilization controls to optimize the use of hospital services are sought while fully-insured patients seek to remain through complete recovery and while chronic patients must remain until a long-term bed is available.

Optimum standards for care are sought while high costs are opposed.

Expanded health benefit programs are incorporated in collective bargaining agreements while consumer and industrial groups oppose increases in health insurance premiums.

Hospitals serve patient and societal needs. The presence of inconsistent patient expectations and contradictory public policies have placed these institutions in the position of trying to do everything for everyone. The absence of disciplined expectations and consistent policies has reinforced and heightened the impact of the five hospital cost components discussed earlier. Effective programs to contain hospital costs will depend on the emergence of more consistent public expectations and clearer public policies for hospital services.

To contain hospital costs in an effective and socially desirable manner, the AAMC believes public and private programs must include efforts (1) to moderate increases in the factors underlying hospital costs, (2) to unify and clarify societal expectations of hospitals, and (3) to design payment systems which provide hospitals with incentives to limit operating expenditures.

A recommended cost containment proposal

As a result of substantial past efforts and legislation, the components of a six point program that would moderate hospital costs are available for rather immediate implementation. The program would be based on (1) implementing a system of uniform hospital cost reporting, (2) publishing hospital cost data to the general community and to community physicians, (3) ensuring that health legislation and regulations are supportive of national cost containment goals, (4) expanding and fully supporting utilization and health planning controls, (5) enacting prospective reimbursement limitations such as those derived from cross-classification schemes, and (6) permitting Medicare to pay State-determined hospital rates where State rate/budget review systems meet necessary Federal standards. Because each of these program components is independent of others, work on them may proceed simultaneously to obtain the maximum cost reduction potential.

Uniform cost reporting

The Nation's hospitals are a set of relatively autonomous organizations separately incorporated and managed. Financial reporting systems within these hospitals have been created to serve the functional needs of management and the documentation requirements of third party payors. As a result of this individuality, it is difficult to compare costs across hospitals. A nationwide system of uniform cost reporting is a most important requirement for the proper measurement, evaluation, and comparison of hospital costs. Uniform cost reporting will help ensure that published information on hospital costs may be meaningfully interpreted by physicians and patients. It will also provide the data for an adequate statistical base to examine hospital cost trends, patterns, and cost containment accomplishments. Therefore, the AAMC strongly recommends the immediate development and implementation of uniform hospital cost reporting system as the first component of a national cost containment program.

Publication of financial data

Hospital cost information should be published and made readily available to both the general and physician communities. In addition to the publication of routine financial statements, hospitals should, on a semi-annual basis, publish information on the charges for frequently utilized hospital services. To help ensure that this data is meaningful, the information should be published in a form which shows the average charges of similar services in similar institutions. The comparative data should be developed and made available to hospitals by the Secretary of HEW. Financial statements and charge data will provide the consumer with some necessary information to compare hospitals.

Because many of the hospital services are ordered by the physician on behalf of the patient, special attention should be given to providing physicians with information on hospital charges. In publishing the charges for frequently used services, hospitals should be required to send a copy of this information to each member of the hospital's medical staff. Consideration also should be given to furnishing the admitting physicians with information on the charges for their patients. In this manner, physicians should become more aware of general hospital charges.

Promoting legislative and regulatory consistency

Each year the Congress considers many bills which significantly affect the cost of hospital operations. In addition, HEW annually promulgates regulations affecting the cost of hospital operations. While many of these bills and regulations may be desirable on their own merits, in the aggregate their impact on hospital costs may be unacceptable. To ensure that the impacts of Federal legislation and regulation upon hospital costs are adequately recognized, the Association strongly recommends that the Congress require every bill or regulation significantly affecting the costs of hospital operations to include a cost impact statement.

Existing programs

In the Professional Standards Review Organization legislation and in the National Health Planning and Resources Development Act, Congress has

attempted to establish programs and policies which will stimulate a more efficient and effective health industry. Unfortunately, both programs have been constrained by their limited jurisdiction, inadequate financial support, and delayed implementation. The AAMC supports full implementation and expansion of PSRO and health planning legislation as a third component in a national cost containment program.

The PSRO program was established to determine that medical services supported with Federal funds are necessary and timely. PSRO agencies are now stimulating changes in the system by altering utilization patterns. As these agencies reduce admissions, length of patient stays, and ancillary services, the increase in aggregate hospital expenses will be reduced. It must be realized, however, that reducing the hospital to care for only the most seriously ill patients will raise the unit cost of services for those admitted. The impact of PSRO agencies can be increased, however, by expanding their authority to include all hospital inpatients. This change would provide an important step in a short-run cost containment program and a foundation on which long-run programs could continue to build.

The health planning agencies established by Public Law 93-641 are also taking effect. With more adequate funding and more timely Federal direction, they could have a more immediate impact on hospital services and facilities which would reduce hospital operating costs. The effectiveness of health planning agencies in containing costs is severely handicapped, however, by the exclusion of noninstitutional services from the mandated Certificate of Need process. For example, in some areas where hospitals and health planners have worked cooperatively to rationally introduce CT scanners, the cost savings to the community have been eliminated by physicians acquiring scanners in office-based settings not subject to review. By controlling capital expenditures only when undertaken in an institutional setting, expenditures are shifting to the uncontrolled non-institutional setting. The AAMC supports broadening the Certificate of Need process to cover all providers, regardless of setting, as one step in fully implementing existing programs to contain costs.

If the jurisdiction of PSROs is expanded to include all patients and if the Certificate of Need process is expanded to include capital expenditures in all settings, further gains in their cost containment potential will depend upon the level of funds appropriated to support them and the Executive agencies diligence in implementing and assisting them. The AAMC fully supports increase government funding, expanded technical assistance, and full implementation for these programs.

Prospective payment limitations

Prospective cost limitations are presently being imposed on hospitals by Section 223 of the 1972 Social Security amendments. While the AAMC has challenged the regulations implementing these routine service cost ceiling, the Association believes this program has had a restraining effect on hospital expenses. A more rational cost containment approach could be based on reimbursement limitations derived from national cross-classification schemes that are carefully constructed to ensure that similar hospitals and costs are being compared and gradually implemented to ensure the attainment of the cost containment goal while minimizing the risk of service disruptions and adverse financial impacts. An appropriately phased system which requires uniform hospital reporting, removes atypical and uncontrollable costs from comparisons, and provides an effective exceptions process could reduce the present rate of hospital cost increases. If incentives were included which enabled hospitals to share in the advantages of reducing costs below the reimbursement limitation, an important stimulus would be added to the present cost containment efforts of governing boards, hospital executives, and physicians.

State rate and budget reviews

In the past decade, several states—including some states with a large number of hospitals—have established mechanisms for reviewing hospital budgets and/or establishing hospital rates. While some of these programs have achieved some success, each has had its effectiveness limited due to the failure of Medicare to participate in the process. The AAMC recommends that legislation be enacted which would permit Medicare to pay state agency determined rates where the state system meets all of the following conditions: (1) it applies to all hospitals; (2) it applies to all revenue sources; (3) its rate/budget determinations are based on the full financial requirements of hospitals; (4) it is an adequately

financed, politically independent agency headed by a small number of full-time, well compensated commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (5) it includes clearly defined formal procedures, adopted after public hearing, for systematic review of rate or budget applications and provisions for routine changes to be made with minimal procedure and expense; and (6) it provides due process, including the right of judicial appeal for the applicant and others affected by the decisions, and specific provisions against undue delays in action. State systems with these features offer one serious long run mechanism for cost containment. Where they are presently established, they also offer immediate reductions in the rate of hospital expenditure increases.

CONCLUSION

It cannot be overemphasized that the present levels of hospital costs have developed over a long period of time and as a result of hospital responses to national and state legislation, the prevailing economic and social conditions and public demands. The problems of instituting controls over the reimbursement system to reduce increases in cost have been described by Alice Rivlin, Director of the Congressional Office of the Budget, in her May 17, 1976, testimony before the Subcommittee on Health of the then Senate Committee on Labor and Public Welfare: "It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in quality of health services, and imposing undesirable rigidities on the delivery system will be a sensitive and difficult task."

After careful examination, the AAMC believes that a six point program based on (1) uniform reporting, (2) published financial data, (3) cost impact statements for new legislation and regulations, (4) fully implemented PSRO and health planning programs, (5) comparative prospective payment ceilings, and (6) Medicare payment of state-determined rates provides an opportunity to commence a national cost containment program which will provide an equitable, realistic, and administerable foundation for a longer run cost containment strategy.

S. 1391, TITLE I

Generic problems of percentage cap

The Association of American Medical Colleges believes that the Administration's proposal of a nationwide cap on revenue is unreasonable in the short-term and that it will have highly adverse effects on our Nation's ability to rationally limit hospital expenditures in the long-run.

The Association is opposed to any proposal which prescribes an arbitrary percentage to cap payments to hospitals. While such an approach does limit third party and patient expenditures and hospital revenues, an arbitrary percentage cap is defective and inequitable by its very nature.

A nationwide cap fails to recognize or account for the very real regional and institutional variations in uncontrollable costs.

An arbitrary percentage increase can unduly benefit hospitals with high proportions of fixed costs.

An arbitrary percentage increase has a relatively punitive effect on the hospital which has already responded to the national objective of containing hospital costs.

An arbitrary percentage increase penalizes hospitals whose costs have been held down by state rate review, for these hospitals start out with a smaller and more restricted base.

An arbitrary ceiling places an unusually heavy burden on tertiary care/teaching hospitals which pioneer new patient care services, must accept referrals of the most costly and complex patients, and are training expanding numbers of new physicians including those specializing in primary care.

In addition to its inherent defects, the Administration's proposal is highly inequitable for the following reasons:

It seeks to limit hospital revenue in the absence of any similar limitations on hospital input prices.

No procedure or controls are proposed for limiting or distributing the volume of patient services required.

Methods to adjust for case mix or patient care intensity are not provided.

There is an implicit assumption that net operating revenues in the base year were adequate to meet the operating revenues in the base year and no relief is provided for hospitals with inadequate revenues in the past.

Each of these four inequities means that some hospitals may easily comply with an arbitrary revenue limitation while other hospitals, of similar or greater efficiency, encounter substantial operating difficulties and financial risk.

The Administration's proposal erroneously assumes that aggregate hospital characteristics are characteristic of individual hospitals.

While the mix of patients cared for nationally by all hospitals may be stable, individual hospitals may encounter substantial changes in patient mix.

The proposal assumes that any single ratio describing the relationship of fixed to variable expenses for the industry.

While the hospital industry has historically maintained a relatively small operation margin of income over expenses, not all hospitals have positive operating margins.

While the proposal assumes that a decrease in the average length of patient stays will decrease per admission costs, it may actually increase costs in individual hospitals while simultaneously reducing revenues.

Because hospitals are not a homogeneous set of institutions, each of which can be individually characterized by nationwide averages, many of the adverse impacts of this proposal must be examined in terms of the individual hospital and its community.

The Administration's proposal ignores historical trends and recent developments in health care delivery which necessitate increased revenues.

Medicare and Medicaid have improved the access and use of hospital services by our poorer and older citizens who often have severe and complex medical needs. The added services that have resulted are a tribute to our nation's hospitals. The costs of these additional services should not be considered as inflation.

Utilization review and medical audit programs operate to minimize underutilization as well as overutilization of health services.

The presence of an arbitrary revenue limitation which does not recognize the justifiable increases accompanying expansion of primary care education threatens to thwart the Congressional intent of Public Law 94-484.

While the trend to increase the number of salaried hospital physicians has increased the hospital's budget, it is not clear that it has increased overall health care costs. An arbitrary cap on hospital revenues in the absence of similar physician controls in the general community, threatens and may reverse this trend.

Each of these four developments in the hospital industry is the result of its continuing evolution. The AAMC believes that these trends should not be indiscriminately reversed by the imposition of an arbitrary limitation on hospital revenues.

The revenue limitations of S. 1391 apply only to the inpatient services of hospitals. While this has been done to foster further development of ambulatory care services, it fails to recognize three key characteristics of ambulatory services: Increased emergency services often increase rather than reduce admissions; increased outpatient clinic services, especially if established in underserved areas, often increase rather than decrease hospital admissions and inpatient days; and increased ambulatory services at many hospitals will require new capital expenditures which are restricted by Title II of the bill. The Association of American Medical Colleges has an active program for the improvement of ambulatory services in teaching hospitals. The proposed legislation threatens that improvement by failing to recognize the relationship between ambulatory and inpatient services and by ignoring the need for additional capital expenditures for ambulatory care services.

Arbitrary revenue limitations, while administratively easy to impose at the payors level, are inequitable, based upon false assumptions of hospital homogeneity, ignore historical trends and recent developments, and do not recognize the inter-relationship of hospital activities. Moreover, by indiscriminately providing highly favorable payments to some hospitals and relatively punitive payments to others, an arbitrary revenue ceiling threatens to disable the hospital industry, to impose irrational and unintended effects, and to create additional residual problems for any long-run containment of hospital costs. Therefore, the Association of American Medical Colleges strongly recommends that Title I of S. 1391 not be enacted.

Special problems with the administration's proposal

The Administration's proposal includes all the problems inherent in an arbitrary percentage cap. In addition, particular provisions of the Administration's proposal impose additional problems.

The formula proposed by the Administration for determining revenue increases is based on an inappropriate measure of inflation, misleads those who use a single percentage to describe the proposal's impact, and adds unnecessary complexity at hospital and payor levels: (1) The GNP deflator reflects both price and commodity changes in the economy. As the Department of Commerce has stated, "it should not be used to measure only price movements." In spite of this strong statement by those who created and calculate the deflator, the Administration has proposed using it. (2) The Administration has argued that their proposal will result in a nine percent increase in revenues. The Congressional Budget Office has estimated that the proposed formula will result in the following revenue increases: fiscal year 1978=8.2 percent, fiscal year 1979=10.2 percent, fiscal year 1980=7.8 percent, fiscal year 1981=6.8 percent, and fiscal year 1982=6.3 percent. By 1980, revenue increases will barely exceed inflation and service improvements will cease. (3) To reduce revenue increases below the otherwise anticipated 14 to 15 percent, hospitals must immediately begin to alter their operations to conform to available revenues. This alteration will be made more complex by the constantly diminishing increase in revenues provided by the GNP based formula.

The Administration's proposal uses a 1976 base year for determining a hospital's revenue limitation regardless of the tenure of the cost containment program. In addition to perpetuating the fiscal problems and spending patterns of 1976 on future fiscal years, the use of an increasingly irrelevant base year will necessitate annual increases in program staff to administer the increasing number of volume adjustments, exception requests, and special problems.

The establishment of at least four separate payment categories under the Administration's proposal for determining revenue limitations for Medicare, Medicaid, other cost-based, and charged-based payors does not recognize the payment characteristics of patients or the operational realities of hospitals: (1) Many patients have been and are supported by two or more of these four types of payors. It would be fiscally irresponsible to classify these multi-payor patients by any single payor, for hospitals could reap unintended windfall above current revenues or highly punitive limitations that are lower than present revenues. (2) The classification of patients by payor assumes each patient may be categorized prior to or upon admission. This is frequently not true for patients supported by Medicaid, workmen's compensation, automobile liability insurance, etc. Thus the hospital would have to accept patients with no knowledge of their eventual revenues to be realized. (3) With per admission revenues limited by class of payor, hospitals will be unable to obtain additional revenues from third-party payors which alter their benefit structure to cover additional, previously unreimbursed, service. Thus, the payors can obtain unintended windfalls at the direct expense of the hospitals. (4) Unless hospitals abandon efforts to provide "on class" service and create separate and defined service units for different classes of payors, the proposal will necessitate four separate hospital control systems. (5) The class of purchaser limitation will have its most severe impact in a State such as New York where the State government has imposed stringent limitations on Medicaid and Blue Cross payments well below the 9 percent recommended by the Administration. These Medicaid/Blue Cross caps and the class of purchaser limitation, in New York, will result in an initial 5 to 6 percent cap in total revenues—a limitation substantially below the initial limitation advocated by the Administration. At a minimum the use of a class of payor will increase the complexity of hospital operations; more importantly, it will reduce revenue increases below the Administration's goals in many institutions.

The final regulations for Phase IV of the Economic Stabilization Program recognized that a limitation on hospital revenues would threaten the financial stability of hospitals unless they were permitted to adjust their revenues for changes in the diagnostic intensity of patients treated. As regionalization, health planning, and possible capital expenditure limitations continue to concentrate the more seriously ill and expensive patients in a limited number of hospitals, these hospitals need a case-mix adjustment to remain financially viable. Otherwise, the combination of health planning and cost containment controls will dramatically reduce the supply of tertiary care services in both poorly utilized hospitals and in major referral centers. The Administration's proposal provides no recognition or adjustment for this impact of patient mix on hospital costs.

The exceptions process proposed by the Administration is wholly inadequate because: (1) it provides no mechanism for necessary additional revenues resulting from changes in diagnostic case mix, (2) it requires a hospital to approach insolvency as a condition of granting any exception, (3) it requires a hospital to spend its unrestricted endowments in order to qualify for an exception, (4) it does not ensure that a hospital improves its current ratio before losing its exception status, and (5) it requires hospitals to accept all recommendations made by an operational review ordered by the Secretary in order to maintain exception status.

The Administration's proposal uses gross revenues because of their computational convenience for hospital payors. However, the use of gross revenues will increase the complexity of hospital operations and add significant uncertainties to revenue projects: (1) The average charge imposed for charged-based payors has no consistent relationship to the amount of moneys received by the hospital since the volume of charity care and the bad debts experience are constantly changing. Thus, the hospital limited to increasing its gross charges has no assurance that its net revenues will actually increase or even remain constant. (2) If cost-based payors alter the provisions of their deductions for contractual allowances, a gross revenue limitation could result in an increase or decrease in net revenues that it is inconsistent with the Administration's intention. (3) Cost-based payors frequently do not make a final determination of payment until 2 to 4 years following an accounting period. Thus, the hospital does not have an accurate gross revenue base to determine its limitation for cost-based payors. The Administration has declared that it wishes to cut the rate of increase in hospital revenue. By using gross revenues rather than net revenues, the Administration's proposal could actually reduce hospital revenues below their present levels.

Each of these particular problems with Title I of S. 1391, as proposed by the Administration, adds to the inherent unreasonableness of a revenue cap as a short-term cost containment mechanism. As a result, the Association of American Medical Colleges is strongly opposed to Title I of S. 1391 as proposed by the Administration.

Special problems with S. 1391, as amended

Throughout May, June, and July, the Subcommittee on Health and Scientific Research of the Senate Committee on Human Resources considered and evaluated the Administration's proposal. In August, the full Committee adopted a significantly amended version of S. 1391. The AAMC is pleased that the Committee did recognize some of the major weaknesses in the original bill. Significantly, the Committee expanded the possibility of State rate review as an alternative to the inherent defects of a percentage cap. Unfortunately, several of the other changes provided at most partial corrections for the original bill's weaknesses: the admissions load formula and exception requirement changes do not provide full recognition for the cost impacts of case mix changes, the provision for HEW to determine future revenue increases provides the Secretary with excessive discretion, and the amended effective date fails to eliminate the essential retroactive controls faced by some hospitals. Thus, the adopted version of S. 1391 continues the inherent defects of the original bill. In addition, two amended provisions add additional shortcomings.

With the exception for States which presently have State-sanctioned rate review agencies, S. 1391, as amended, would impose a mandatory pass through of wage increases for non-supervisory employees. This provision will undoubtedly increase the demands of these personnel for significant wage increases, a demand that is in direct conflict with bill's cost containment objective. Moreover, wage increases granted (and passed through) for non-supervisory personnel will probably determine the wage increase expectations of all other hospital personnel. Without a similar exemption for these latter employees, the hospital may be unable to fulfill expectations; morale will decrease, turnover will increase, and the relationships between supervisory and non-supervisory personnel will deteriorate. Thus, the wage pass through provision is undesirable in terms of the bill's objectives and the provision's likely impact on hospital operations.

Secondly, the amended S. 1391 adds a new section which permits any citizen to initiate Federal Court action against any hospital which the citizen believes has violated the act or its implementing regulations. While the citizen must notify the Secretary of HEW of his intent at least 60 days prior to filing the suit, this provision may stimulate numerous groundless suits. Hospitals must respond to

such suits by using available financial resources to purchase legal services rather than to provide health services, an outcome which is in conflict with the bill's objective.

S. 1391, as amended and adopted by the Senate Human Resources Committee, retains a cost containment approach based on a fixed percentage cap. In spite of several amendments, it retains the inherent weaknesses of that approach, and it includes new provisions introducing significant new shortcomings. Therefore, the Association of American Medical Colleges is strongly opposed to Title I of S. 1391 as adopted by the Senate Human Resources Committee.

S. 1391, TITLE II

General approach of capital expenditure limitation

Title II of the proposed "Hospital Cost Containment Act of 1977" (S. 1391) would establish permanent limits on hospital capital expenditures of the type, size and scope presently controlled under both Section 1122 of the Social Security Amendments of 1972 (Public Law 92-603) and the "Certificate of Need" provisions of the National Health Planning and Resources Development Act of 1974 (Public Law 93-641).

Before considering this new proposal, it is useful to examine the evolution of health planning in our nation. In 1965, the Regional Medical Programs Act (Public Law 89-239) was passed to promote regionalization, local participation in health planning, and a dual funding mechanism for both planning and operations. However, RMP's potential contribution to health planning was rendered negligible, in significant part due to inadequate funding, a lack of policy guidance, and needed technical assistance. In 1966, the Comprehensive Health Planning Act (Public Law 89-749) was enacted to promote comprehensive health planning for services, manpower and facilities at every level of government, primarily through a strengthening of leadership and capacities of State health planning agencies. CHP "B" agencies were chronically underfunded due in part to appropriations below authorization, and in part due to an inability to raise local funds to meet Federal matching requirements.

In 1972 Section 1122 of the Social Security Act was enacted to tie Federal reimbursement for capital expenditures to the planning process by requiring prior notification of a capital expenditure proposal by health care institutions and by further requiring a determination by the planning agency of the proposal's consistency with standards, criteria or plans developed on an areawide basis.

The current national health planning law, Public Law 93-641, combines the best features of each of its predecessors into a single program of State and local planning and development. Nevertheless, though authorization levels under Public Law 93-641 substantially exceed previous CHP funding levels, the issue of adequate funding for health planning remains a concern.

In the past 12 years, our Nation has had four major health planning programs. The Administration is now proposing a fifth major change, one that would combine the local focus of health planning with a nationwide ceiling on total capital expenditures and with nationwide standards for bed supply and hospital occupancy. With this past history, the AAMC urges the Members of Congress to ask whether it is logical to continue every few years to enact new federal health planning legislation to replace previous statutory programs that failed because they were poorly financed, ill-staffed and not given a fair chance to succeed. Or, has the time come to permit the current planning law an adequate opportunity to fulfill its promise by strengthening and improving existing mechanisms (i.e., capital expenditure review, Certificate of Need and review of new institutional health services) through increased government commitment in funds and priorities? The Association believes that, if the present health planning law is allowed to operate effectively, it will provide the necessary mechanisms to review and determine the need for proposed capital expenditures.

Earlier this year, Congress adopted legislation which extended the present health planning act for an additional year. The Association of American Medical Colleges supported the extension in the understanding that the additional year would provide a period to comprehensively evaluate the present planning act. Title II threatens to undermine that comprehensive review by undertaking a major, but piecemeal, change in the national health planning program. The AAMC is strongly opposed to such a piecemeal change and recommends that the entire issue be deferred until it can be considered in its planning context.

When the National Health Planning Act is being reconsidered the AAMC will make several recommendations for changes in the Act, including the following which would provide a more effective means of achieving an efficient use of capital expenditures by hospitals and other providers in the health care industry:

The National Health Planning and Resources Development Act of 1974, Public Law 93-641, must be strengthened and improved by means of increased government funding and technical assistance to give the health planning law the opportunity to further local areawide planning and determination of need.

The Certificate of Need process under Public Law 93-641 should be strengthened so that all States will possess an operating approved program to review and determine the appropriate use of capital expenditures. The definition of "new institutional health services" under the Certificate of Need program should be broadened to include all providers of health care, regardless of the setting.

The DHEW is strongly urged to perform or commission studies on approaches to introduction, deployment and cost-benefit analysis of expensive new medical technology (e.g., CT Scanner).

DHEW is strongly urged to undertake or sponsor cost-benefit studies of mandated capital requirements of hospitals and provide valid data for later reference on this subject.

The government should establish positive incentives for providers to bring the health care facilities and services available in an area in line with community needs. Such incentives may be provided through the reimbursement mechanism or capital expenditure review process. Mergers, shared services and other cost containment efforts should be promoted while preserving or improving high quality care.

Public Law 93-641 will, if allowed to operate up to its maximum potential, induce hospitals to be more critical and rational in their growth and program development and to relate these plans to those of other institutions and to the needs of the community.

Specific problems with the administration's proposal

Title II of S. 1391 is arbitrary by its very nature. Prior to the beginning of each fiscal year, the Secretary of HEW would establish an annual national limit on new capital expenditures by acute care hospitals under Title II of the proposed hospital cost containment act. The amount of this limit may not exceed \$2.5 billion. This ceiling is much too low, and would necessitate an immediate drastic cut of about 50 percent in the current level of capital expenditures (approximately between \$5-\$6 billion) by acute care hospitals in this country.

The capital expenditure ceiling is not only arbitrary, it is also inflexible. While the provisions of Title II are permanent, they contain no language that would leave room for exceeding the \$2.5 billion figure under any justifiable circumstances. Thus, hospitals would be confronted by a permanently fixed ceiling, inadequate at the start and becoming more so in later years as construction and equipment costs increase.

The AAMC is opposed to the \$2.5 billion ceiling not only for the reasons already described, but also because it fails to consider the sizeable capital expenditures that hospitals must make each year in order to comply with mandatory changes required by various codes, standards and regulations to which the hospitals must conform. Among the more frequently identified codes and standards are:

1. Joint Commission on Accreditation of Hospitals.
2. Section 504 Regulations on Discrimination Against the Handicapped (45 CFR, Part 84).
3. Inspection standards and codes for Federal and State hospitals other government facilities.
4. Manufacturer's standards and instructions for operating equipment and devices.
5. American National Standards Institute standards.
6. National Electrical Manufacturers Association codes and standards.
7. Underwriter's Laboratories standards.
8. American Society of Heating, Refrigeration, and Air Conditioning Engineers standards.
9. Electronic Industries Association standards and publications.
10. Institute of Electrical and Electronic Engineers standards and related publications.

11. American Society for Testing and Materials standards.
12. Instrument Society of America standards and recommended practice.
13. U.S. Department of Health, Education, and Welfare, Public Health Service, Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities.
14. National Safety Council safety-evaluation checklist.
15. Model Code Groups/Southern Standard, Building Officials and Code Administrators, Uniform Building Code.
16. National Fire Protection Association.

These public, governmental and industrial bodies have exerted increasing pressure on hospitals to meet increased environmental and life safety standards that mandate changes which by themselves could require acute-care hospitals in this country to expend as much as, if not more than, the \$2.5 billion figure that has been proposed as a national capital expenditure limit under S. 1391.

Unfortunately, the magnitude of the capital invested yearly by hospitals on mandatory changes required by such sources as the Life Safety Codes is not well documented. But enough is known to realize that the proposed \$2.5 billion ceiling on national capital expenditures is a capricious recommendation that might even fail to keep hospitals abreast of their current basic capital needs. Hospitals are beset with standards and regulations to which they must conform in order to keep their doors open. For teaching hospitals, JCAH Accreditation requirements are critical for without such accreditation the hospital may lose its educational accreditation. Thus, the AAMC opposes the arbitrary \$2.5 billion cap proposed under Title II, but strongly urges HEW to undertake detailed cost-benefit studies of the mandated capital requirements of hospitals and provide valid data on this subject for future reference.

S. 1391 also requires the Secretary to establish for each fiscal year a national ceiling for the supply of beds within health service areas and a national standard for the rate of occupancy of hospital beds within such areas. No projects resulting in net bed additions will be approved in health service areas with more than 4 beds per 1,000 population or less than 80 percent occupancy of hospital beds. These arbitrary standards have been challenged in the past and are strongly opposed by the AAMC. They are insensitive to local needs and conditions, to interarea migration of patients for tertiary level care, and to the difficulties and costs of local planning to accommodate such federally imposed mandated formulas. They ignore the fact that rural hospitals need a wider margin of safety than an arbitrary floor of 80 percent occupancy would allow. There are a number of medical centers which function as national referral resources which must maintain bed-to-population ratios in excess of the standard established in the President's proposal. Such areas as Durham, N.C. and Rochester, Minn. are well recognized examples of such referral resources.

Additionally, it remains unclear how the term "beds" is defined in each area. Are the standards applicable only to an institution's total licensed beds? Its total bed capacity? The total beds staffed and in operation for a given period of time? Only acute care beds? Are special care units to be included in the computation? Finally, while the provisions leave some room for flexibility by stating that the Secretary may establish a different supply ceiling or occupancy standard for health service areas which have special characteristics or which meet special requirements, the bill provides no guidance as to what these special characteristics or requirements might include.

The AAMC recognizes and concurs in the need to eliminate excess beds and to raise occupancy rates in some areas. The Association has supported utilization control mechanisms such as utilization review (UR), Professional Standards Review Organizations (PSROs) and the JCAH, and is working to make the product of these efforts more meaningful and useful. However, the Association questions whether an annual bed supply ceiling of 4 or less beds per 1,000 population and an 80 percent or above minimum occupancy rate for a health service area are standards which are workable and based in reality.

In summary, the Association of American Medical Colleges is strongly opposed to the permanent and arbitrary limit on hospital capital expenditures, the ceiling on the supply of hospital beds and the standard for occupancy of hospital beds to which short-term acute care hospitals would be subjected under Title II of the Administration's Hospital Cost Containment bill, S. 1391.

Specific problem with S. 1391, as amended

S. 1391, as amended by the Human Resources Committee, imposes a moratorium—with certain exceptions—on capital expenditures. While the amend-

ments which include non-institutional providers and which exclude mandated facility changes are consistent with the planning act amendments recommended by the AAMC, the Association opposes the proposed moratorium: because it makes a significant piecemeal change in our nation's health planning program, because a moratorium is even more arbitrary than an expenditure cap, because the termination of the moratorium is tied to a planning process not yet in place, and because the conclusion of the moratorium simultaneously introduces the arbitrary expenditure ceiling advocated by the Administration. The Association urges Congress to refrain from adopting this proposed moratorium and recommends that Title II of S. 1391, as amended, be considered in a comprehensive review of the planning act.

S. 1391, title II: an unresolved issue

Current cost containment initiatives have been undertaken at HEW under the health planning program and the AAMC is concerned about the juxtaposition of the recently proposed National Guidelines for Health Planning in relation to the Administration's hospital cost containment proposal. The AAMC urges recognition that the impact of these guidelines, in conjunction with the limitations of S. 1391, may well lead to a number of extremely objectionable consequences.

Under the utilization standards set forth in the proposed guidelines, many low volume hospital services, such as obstetrics, cardiac catheterization and open-heart surgery, would have to close and the implementation of revenue limitations as proposed by the Administration would provide an economic incentive for other such closures. The changing referral patterns for such services would bring the patients who formerly received care from these hospital programs to tertiary care centers—academic medical centers and teaching hospitals—for the services. Given the imposition of revenue caps and the fact that services addressed by the guidelines are mostly of a high-cost nature, the tertiary care referral centers may be placed in a position where their revenue capacity will be inadequate to accept these additional patients. The net impact of this desirable regionalization of high technology services could mean drastic reductions in their availability as hospitals with inadequately utilized services drop them and as inadequately reimbursed medical centers find they are unable to support added tertiary care services. This incomplete regionalization would leave many patients who need tertiary care services in the extremely difficult, if not desperate, situation of trying to obtain services in short supply. It could be financially devastating to the academic medical center/teaching hospital faced with increasing demands for a service it cannot afford to provide.

The AAMC has supported the strengthening of the health planning program; however, the stronger cost containment orientation taken by HEW in the proposed National Guidelines, together with the currently proposed cost containment legislation, S. 1391, would undoubtedly lead to an extremely undesirable situation with regard to the future availability of tertiary care services in this Nation. The Association requests that the Administration consider the implications discussed and respond to this issue.

S. 1470, AS EXPANDED

A review of the summary description for the expanded version of S. 1470 clearly demonstrates that the Subcommittee and its staff have given careful consideration to suggestions made by witnesses at previous hearings. For this thoughtful approach and for the staff's willingness to discuss general concepts and tentative provisions, the AAMC expresses its appreciation to the Subcommittee and its Chairman. The Association recognizes the Subcommittee's commitment to stimulating an efficient, effective and equitable cost containment program which serves the needs of the population and moderates hospital expenditures. Comments made in this written testimony are based on the distributed outline of the bill, and the Association would be willing to offer more definitive comments as more complete information about the bill is made available.

Teaching hospitals are not a set of homogeneous institutions with similar organizational structures, staffing patterns, financial resources, patient care and educational programs, or facilities. They vary widely on these and other dimensions, for they have evolved to meet local, regional, and national missions within individual organizational and social constraints. Given this broad diversity, the Association of American Medical Colleges has consistently advocated and supported hospital payment mechanisms which recognize the individuality of each institution and which make hospital comparisons only among truly

similar institutions. The Association has recognized that payment limits derived from cross-classification schemes that are carefully constructed and conscientiously implemented to ensure comparability of institutions and costs are one legitimate approach to containing hospital payments.

General comments

Uniform cost reporting

A most important prerequisite for the proper measurement, evaluation, and comparison of hospital costs is the development and implementation of a system of uniform cost reporting. Therefore, the Association supports the requirement for uniform hospital cost reporting.

Classification of hospitals

A fundamental concern of the Association is the criteria used to establish any hospital classification system for calculating hospital payments for routine and ancillary services. While the Association is pleased that the legislative outline provides the Executive Branch with some flexibility in implementing the Congressional intent, the AAMC remains concerned about this issue.

For the proposed approach to function as envisioned by its designers, the hospital classification scheme must be carefully constructed to group together essentially similar institutions. As this Association has testified before, hospital classification is at an elementary state-of-the-art. Moreover, there presently is a lack of adequate data for analyzing the impact of alternative grouping criteria. In this situation, the Association strongly recommends that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review program progress, monitor program implementation, examine problems encountered and make recommendations regarding appropriate solutions for problems identified. The advisory board to be established should include representatives from the Legislative and Executive Branches of Government, as well as knowledgeable individuals from the private sector. In addition to its technical expertise, this advisory board would provide public visibility for the decisions implementing these amendments. The Association's experience with the implementation of the payment limitations of Section 223 of Public Law 92-603 leads it to strongly recommend such an advisory board.

Exceptions

Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends that developed legislation include provisions for an exception and appeal process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions so that the initial application for an exception is judged complete; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the Secretary be required to regularly publish base line or typical costs for each group of hospitals in the classification system; (4) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (5) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or reduction in the per-admission costs.

The AAMC is pleased that the proposed exception provision requires that action on a properly filed request be completed in forty-five days or the request will be deemed approved. This would be a significant improvement over the present situation provided that DHEW or the intermediary do not consistently rule applications incomplete on day forty-four.

State rate control authority

The Federal Government is the source of funds for the Medicare program and shares in the funding of Medicaid; however, apart from an aggregate payment cap, the legislative outline provides no Federal payment or operational standards for the state rate setting agencies. As proposed in the outline, a state could use Medicare/Medicaid participation in a state rate setting/budget review process to dramatically, arbitrarily, and capriciously reduce hospital payments below

the level authorized by Federal regulations. If the state option were used in this manner it could undermine the financial integrity of many hospitals. Therefore, the AAMC's position is that state rate systems are acceptable where they meet the following conditions: (1) the system is based on the full financial requirements of hospitals; (2) the System is based on an adequately financed, politically independent agency headed by a small number of full-time, well-compensated commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (3) the agency's operations include clearly defined formal procedures, adopted after public hearings, for systematic review of rate or budget applications and with provisions for routine changes to be made with minimal procedure and expense; and (4) the agency provides due process, including the right to judicial appeal for the applicant as well as for others affected by the decisions, and specific protections against undue delays in action.

Excluded costs

In the past, the Association has not specifically advocated a cross classification approach to cost limitations. Rather, if a cross-classification approach is to be used, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product produced or to characteristics of the production process. Therefore, the Association believes that the exclusion of capital and related costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and nonadministrative physicians; energy costs associated with heating or cooling the hospital plant; and malpractice insurance expense is a step in the proper direction. The legislative outline for the proposed bill is unclear, however, as to how these costs would be included in the proposed revenue ceiling and the AAMC requests clarification of this point.

Routine service cost observations

Last June, the AAMC appeared before this subcommittee to provide Association views on the provisions of S. 1470 as originally proposed. Without reiterating each specific evaluation and concern, the AAMC would like to note that its positions on the bill's hospital payment provisions have not changed. The Association continues to recommend that the bill call for hospitals to "be classified by type and size" with specific guidance in the Committee Report, that the provision for a specific category for the "primary affiliates of accredited medical schools" be deleted, that the Secretary of HEW be directed to examine the reimbursement implications of alternative definitions of the term "teaching/tertiary care hospitals," that the Executive Branch be provided with flexibility to specify payment ceilings with guidance in the Committee Report, and that exceptions for the cost impacts of diagnostic case mix be retained.

In determining the routine service revenue limitation in the base year and its increase in subsequent years, the legislative outline is unclear as to whether routine service ceiling computations will be based on presently allowable costs without regard to ceiling limitations and incentive payments or on actual payments, including ceilings and incentive payments. The Association requests clarification of this issue and strongly recommends that, in computing adjusted routine service costs, a previous accounting period's allowable costs will be used in the calculation without adjustments for incentive payments or reimbursement penalties.

Ancillary service revenue observations

Charges below costs

In proposing a hospital payment system based on past revenues for ancillary services, some adjustment mechanism should be provided for the hospital with operating expenditures in excess of net revenues for the base year. Otherwise, hospitals in a deficit position during the base year will either remain in a deficit position throughout the period of years being controlled or become financially unstable. To avoid undermining a hospital because of historically inadequate revenues, the Association strongly recommends, if a revenue limit approach is to be developed, that a hospital be permitted to use its base year ancillary service expenditures as its base where revenues received were less than actual expenditures.

Ancillary cost indexes

The legislative outline provides that interim ancillary services revenues limits would be increased by national price increases in goods and materials purchased.

The reasonableness of this approach rests on the specific price indexes used to update the revenue limit. If the selected or developed indexes accurately measure price changes encountered by hospitals, the approach may provide hospitals with adequate revenues. If the indexes employed do not accurately reflect price changes incurred by hospitals, revenue windfalls or shortfalls will develop. The recommendation and evaluation of proposed indexes for this adjustment to ancillary service limits is a good example of an issue which could be brought before the above-proposed National Technical Advisory Board.

Base year

The legislative outline proposes using a 1976 base year for determining ancillary service revenue limitations regardless of the tenure of the interim cost containment program. In addition to imposing the fiscal problems and inequities of 1976 on future fiscal years, the use of an increasingly distant base year will complicate program administration by increasing the number of exception requests and special problems. This rigidity and expense can be avoided by allowing a previously controlled fiscal year to serve as the base period for the present year. The AAMC strongly recommends this change in base year selection.

Special care units

In the past few years as standards for hospital care have changed, hospitals have added special care units for coronary care, intensive care, burn care, kidney care, and other specialized services. Treatment of these units as routine services would decrease the comparability of costs across hospitals. Moreover, it is not at all clear what price indices should be used for the goods and services used or for their highly technical personnel. Therefore, the AAMC requests clarification of the treatment of special care units under the proposed legislation.

Volume adjustments

The volume adjustment for ancillary services proposed in the legislative outline provides a 50 percent marginal revenue limit on admissions beyond 102 percent and below 90 percent of the previous year's admissions level. While this position seems clear, the examples provided in the outline are confusing with the reduced admissions adjustment being especially restrictive. If a marginal revenue limit is to be imposed for volume changes, the AAMC recommends that marginal revenue reductions below 90 percent of the previous years volume be subtracted from allowable revenues calculated at 100 percent of last year's volume. Otherwise, a hospital incurs both an average revenue and a marginal revenue reduction. The combination is sufficiently severe that it might destroy the desired cost containment incentive to treat appropriate patients in other, less expensive, settings.

Conclusion

The Association is pleased to have this opportunity to comment on the outline of the proposed bill and thanks the Chairman, Subcommittee members, and staff for this consideration.

Senator TALMADGE. The next witness is Dr. Robert B. Hunter, chairman, Board of Trustees, American Medical Association.

Dr. Hunter, we are happy to have you back before the committee again, sir.

STATEMENT OF ROBERT B. HUNTER, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. HUNTER. Thank you, and good morning.

With me today is Harry Peterson, director of our department of legislation. I will summarize in an effort to be brief, Mr. Chairman.

At the outset, I want to state that physicians across this Nation join your subcommittee and the public as a whole in their concern about the rising costs of health care. Just as we need to find a solution to this problem, it is equally important, however, that any solutions imposed should not merely substitute new and equally significant problems.

As Congress is most acutely aware, available resources for health care are finite. It is therefore inevitable that difficult decisions will have

to be made at some point with respect to how much of our resources can be allocated for health care services. Yet, we must counterbalance that choice with the recognition that arbitrary limits will mean that not all persons can obtain all desirable medical care.

When approaching the question of cost containment, we must keep in mind that the decisions made today cannot be quickly reversed 10 years, or even a few years, down the road. It takes time to build a system, and it takes constant infusions of resources to maintain that health care system at a high level of quality. Decisions made today will reverberate for years to come.

We must not lose sight of the fact that arbitrarily cutting costs will result in lessened quality of care. A decade ago, the major concern in our society with respect to health care delivery was the question of access. To a large extent, private, State, and Federal programs have alleviated the problem of access to adequate health care for the majority of our citizens.

Today, we face another issue—the cost of providing these health care services. There is little question that health care costs are rising rapidly, or that rising costs are a concern to all of us. We point out that rising health care costs are not the result of any single force. For example, there has been a tremendous increase in technological advancements in the provision of health care. With new advances, there is the need for increased sophistication in medical facilities and equipment and the need for more highly trained individuals to utilize and make real for our patients those same advances.

In addition, inflation and sharp wage increases continually push costs higher. And of course, one can look at the infusion of patient care funds into the health care system, both through private insurance and through governmental resources, such as the medicare and medicaid programs. Yet, in the last analysis, the patient, when he is ill, wants and deserves only the best that our system can provide.

We, physicians, want no less for our patients.

I would like to turn first to your most recent containment proposal, Mr. Chairman.

It is our understanding that the proposal on which you have requested comment is not available in legislative language. As we understand the proposal, there would be two general limitations on cost containment: One, an overall limit on hospital revenues for inpatient care, and the other, a special limitation on hospital reimbursement under medicare and medicaid. Within the inpatient hospital cost constraint provisions, distinction would be made between routine costs and ancillary costs. Limits on routine service revenue would be determined by: Grouping hospitals, computing an average cost per diem; and then comparing the per diem costs of each hospital within the group to the group average.

Total amount allowable for routine costs would be equal to the per diem times the total inpatient days. While no absolute dollar limits would be imposed, amounts in excess of total allowable per diem are subject to penalty. However, as the program would be extended to encompass ancillary costs, "caps" on revenues for ancillary services would be computed. These limits would operate in much the same manner as the administration's "cap" program.

State hospital regulatory activities could be accepted in lieu of the Federal limitations where such State regulations apply to at least the same hospitals and services as the Federal program and where the State limits hospital revenues.

Until the proposed amendments are proposed in specific statutory language, it is necessary for us to address the proposed amendments in general terms.

One of the principal changes for your Senate bill, S. 1470, is the delineation between computation of routine revenue limitations and ancillary revenue limitations which we discussed above. A further change would extend the per diem determination to all hospital patients, and not just to medicare and medicaid patients.

Morover, since the revenue limitation on ancillary services would operate to allow hospitals to retain only 50 percent of the costs when admissions exceeded 2 percent over the base year, we fear that this, like the administration proposal, would have the effect of discouraging an increase in otherwise needed patient services.

Mr. Chairman, there are many complexities inherent in this proposal. For instance, several factors affecting the per admission ancillary service allowance would have to be taken into consideration, such as wage increases in the locality and the determination of a newly designed national market basket index for goods used in connection with ancillary services. Apparently new but unspecified limitations would be imposed on medicare and medicaid expenditures.

While I recognize that our comments are not detailed at this time, we would be happy to comment further when legislative language becomes available. We do note that many of the provisions contained in these proposed amendments appear similar to, or would incorporate provisions of, S. 1470.

In our testimony on S. 1470 before this same subcommittee, we pointed out our concerns over the limitations that would be imposed and, while we support appropriate programs for cost limitations, we urged at that time that the cost containment program of S. 1470 should be initiated under an experimental, geographically localized, program prior to any nationwide application and commitment.

We believe that there would be merit in considering experimentation with any program developed under the proposed amendments.

The committee is to be commended for these hearings to seek a public review of the potential ramifications of this involved program. We will continue to study your proposal as new developments unfold, and would be happy to provide any assistance we can to your committee.

Relative to Senate bill 1391, as approved by the Senate Human Resources Committee, this would establish a Federal program setting arbitrary limits on hospital inpatient revenue increases, placing a moratorium on capital expenditures, including certain medical equipment in physician offices, limiting aggregate capital expenditures to a nationally determined level allocated through the States and modifying the health planning law to allow, among other items, decertification authority to the States.

In regard to the first, we believe that the proposed cap limitations on hospital revenues are inappropriate, artificial limitations, irrespec-

tive of how generous or how restrictive or unrealistic. In order to provide an uninterrupted flow of hospital care which the American people demand, a hospital must keep pace with technological advances.

No patient wishes to be admitted to a hospital which he believes is not a modern hospital. A reimbursement limitation on hospitals which does not allow increases reflecting true cost increases could have the effect of unfairly and inappropriately restricting increased expenditures by hospitals when those increases are necessary due to increased service, better equipment or more highly skilled staff.

In regard to the second major program of S. 1391, this would impose a moratorium on capital expenditures in effect until September 30, 1979. During this time, no capital expenditures for equipment or facilities to provide health care directly or indirectly could be made except in certain limited situations.

A capital expenditure is defined as an expenditure of \$150,000 or more, or one which changes the bed capacity or substantially changes the services of the facility. Included also would be physicians' medical equipment in his office.

We fear that such absolute limitations on the amount of capital expenditures would only benefit inefficient hospitals by preventing competition. Indeed, this total national limitation of \$2.5 billion is estimated as being only 50 percent of current levels of annual expenditures.

Senator TALMADGE. Thank you very much. Your full statement will be put in the record and studied by the subcommittee and the staff.

Are there hospital administrators, to your knowledge, that place pressure on medical staffs to admit patients, extend stays, and overservice?

Dr. HUNTER. In my 30 years of practice, I have never encountered it.

Senator TALMADGE. Dr. Hunter, as you know, many of the cost containment bills and provisions and existing law require approval before costly equipment may be installed in hospitals. Congressman Rogers has proposed similar approval requirements before that equipment could be installed in noninstitutional settings, such as physicians' offices.

If a hospital is required to get approval before it can install a CAT scanner, should a physician, or a group of physicians, be required to secure similar approval?

Dr. HUNTER. I believe that such a concept would be totally foreign to the free marketplace, Mr. Chairman. I do not believe that anybody would make an expenditure of this magnitude unless he thought that the need was there.

Senator TALMADGE. Senator Dole, any questions?

Senator DOLE. Along the same lines of the first question that Senator Talmadge asked, we had testimony yesterday from Secretary Califano about too many patients going in on Friday for custodial care over the weekend. The administrators say that they do not control the flow of that, doctors do; and I referred to this week's U.S. News & World Report that has very lengthy discussions of hospital costs and the fact that 70 percent of the costs are related to what doctors do, not what administrators do.

[The article referred to follows:]

[From U.S. News & World Report, Oct. 17, 1977]

AMERICA'S DOCTORS/A PROFESSION IN TROUBLE

(By Abigail Trafford Brett)

The American medical profession is in trouble.

Never has medical science been as powerful to deal with disease. Yet never has the profession faced so many questions about its integrity, its competence or its role in society.

Americans are living longer today than ever before. Infant-mortality rates have been cut by nearly half, and the country's No. 1 killer, heart disease, is on the decline.

Even so, the growing capacity to heal the sick is matched by what many doctors see as their incapacity to manage a profession in danger of being overwhelmed by its advances in technology and overtaken by new forces.

No longer are doctors considered almost sacred—though public-opinion polls still rank physicians far ahead of lawyers and politicians as the most-respected profession.

Within medicine's own ranks, more doctors are speaking out on soaring medical costs, exploitation of government health programs, and mental illness, alcoholism and addiction among numbers of their colleagues. At the same time, local medical societies and State licensing boards are accused of lagging in efforts to protect the public—or the profession—from problem doctors. As a result, malpractice suits have multiplied, medical law is a booming specialty and the "patients rights" movement is in full swing.

Over the profession, meanwhile, looms the enlarging shadow of government as the Great Medical Regulator. Hospitals are the first target of the Carter Administration. Doctors may be next. The era of the solo practitioner is drawing to a close, and group health practices, local planning agencies and peer-review systems—all connected to Washington—threaten medicine's rugged individualism of the past.

More and more, doctors realize that the next few years are critical to the future of medicine in the U.S.—and to the profession itself. Caught in a time of transition, many are taking steps to stiffen discipline within the profession and confront the developing controversies over health care.

Says Dr. Leon R. Kass of Georgetown University's Center for Bioethics in Washington, D.C.: "American medicine is not well. Though it remains the most widely respected of professions, though it has never been more technically powerful, it is in trouble, both from without and within."

THE PRICE OF MEDICAL PROGRESS

In many ways, the country's 340,280 physicians are victims of their own success and resources. Today's doctors are, on the whole, better trained than ever before. Competition to get into medical school is stiffer and academic standards are higher. State licensing-board examinations are harder, recertification procedures have become more stringent and, in recent years, training programs to keep physicians up-to-date have proliferated.

Unlike their grandfathers, whose technical expertise fitted into a black bag, today's doctors are surrounded by impressive aids: surgical techniques to replace hips and rebuild disfigured faces, giant X-ray machines that penetrate bone and map the soft-tissue landscape of the body's interior, and drugs to treat cancers and mental illness, to name just a few.

No longer is there a nationwide shortage of doctors or hospital beds. Medical schools have doubled their capacity since 1960, and in the last five years the number of physicians has jumped 30 percent.

By 1980, there will be 1 physician for every 490 people—the highest doctor-patient ratio in the U.S. since the turn of the century. The number of para-professionals, trained in health care but lacking a medical degree, is also increasing.

Instead of worrying about a doctor shortage, health officials are concerned that, in most sectors, the U.S. may soon have too many people treating patients. That could further increase the country's total health budget and worsen the potential problem of unnecessary treatments.

With all of this, physicians enjoy the highest income of any profession. By 1978, Government officials estimate, physicians will make an average of \$75,000 a year.

Dr. Theodore Cooper, former Assistant Secretary of the Department of Health, Education, and Welfare and now at Cornell University Medical College, comments: "It's the fashion these days to talk about what is wrong with medicine, to characterize its practitioners as avaricious, insensitive and even incompetent. That is a paradox, indeed almost schizophrenic, when measured against the great success of the past decade of American medicine. One could rightly say of American medicine today: 'Never has anything sounded so bad that has actually been so good.'"

Overspecialized profession. Much of the criticism is rooted in the very changes since World War II that account for medicine's success: the specialization trend among physicians and the growth of medical technology.

In 1950, half of the country's physicians were general practitioners. Today only one seventh of the country's physicians are in primary care—general practice—although 90 per cent of the problems that send patients to doctors do not require any specialty training.

According to 1975 statistics from the American Medical Association, 53,576 of the 340,280 licensed physicians were in general practice, 258,361 in different specialties from aerospace medicine to allergies, 6,445 in teaching, 11,161 in administration and 7,944 in research.

Thus, even as the over-all supply of doctors increases, health officials worry that there are too many specialists, as well as too many doctors in affluent metropolitan areas—with not enough doctors interested in general practice and disease prevention or willing to practice in rural areas and inner cities where the need is greatest.

The trend toward specialization is tapering off. A new law governing distribution of federal funds to medical schools now requires that half of the residency programs be in general medical care. Yet major gaps remain: By the year 2000, for example, more than 31 million Americans will be over 65, and studies show that they require 2½ times more medical care than younger age groups. Robert Derson, HEW director of health-care financing, asks: "We have pediatric cardiologists as specialists, but where are the physicians to treat our older population?"

This conclusion comes from HEW's Karen Davis, who is in charge of health planning: "The No. 1 problem with the medical profession is maldistribution. We've got the wrong kinds of doctors in the wrong place doing the wrong things."

Machines vs. personal touch. Technology, too, has exacted its price. Doctors tend to rely more on tests than their own judgment. As a result, costs are up and the doctor-patient relationship is down.

What's more, there is a growing recognition among professionals that medical science, for all its expertise and "gee whiz" machines, actually has a limited impact on control of today's major diseases—heart ailments, cancer and others. Far more important may be diet, behavior and environmental conditions in determining the toll from such illnesses.

As Dr. Eric J. Cassell of Cornell University's Medical College explains: "Apparently medical care alone, no matter how well delivered or technically complete, cannot be expected to lift the burden of sickness."

"Even if present surgical techniques were perfected, the value of a new or repaired heart in the body of a patient whose life style remained otherwise unchanged would not be very high."

Yet, specialization in medicine and technology's dominance are here to stay—bringing a subtle but significant shift in the status of the physician.

Dr. Irvine H. Page, heart specialist at the Cleveland Clinic, explains: "We tend to idealize the horse-and-buggy doctors. . . . Their professional status was never in doubt. Physicians were expected to be unworldly, dedicated and idealistic, with a high sense of human responsibility. Their knowledge and scientific achievements were of much lesser importance."

Now the situation is reversed. Physicians' knowledge and scientific achievements are well established. It is their professional status that is in doubt and the use of these new tools that is being questioned.

PROFILE OF AMERICAN DOCTORS

Among 340,280 physicians practicing in the U.S. and its possessions—

Sex

9 out of 10, or
91%, are men



Age

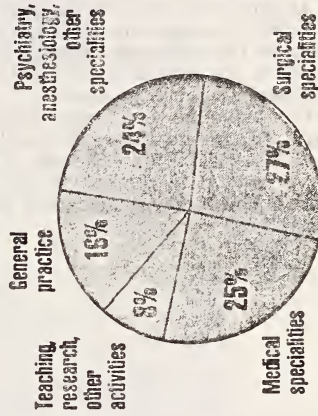
Average, 46 years	
Under 35 years	28%
35-44 years	24%
45-54 years	21%
55-64 years	14%
65-74 years	9%
75 years and over	4%

Income



Average \$58,440 from medical activities in 1975, latest available, and well above that today

Specialties



Location

About half live in seven States:

New York	13%
California	13%
Pennsylvania	6%
Illinois	5%
Texas	5%
Ohio	4%
Florida	4%

THE HIGH COST OF HEALING

The current attack on physicians has largely come out of the crisis in health costs. The Carter Administration has given cost-control measures top priority, and 3 out of 4 doctors, according to an AMA poll, consider medical costs their biggest problem.

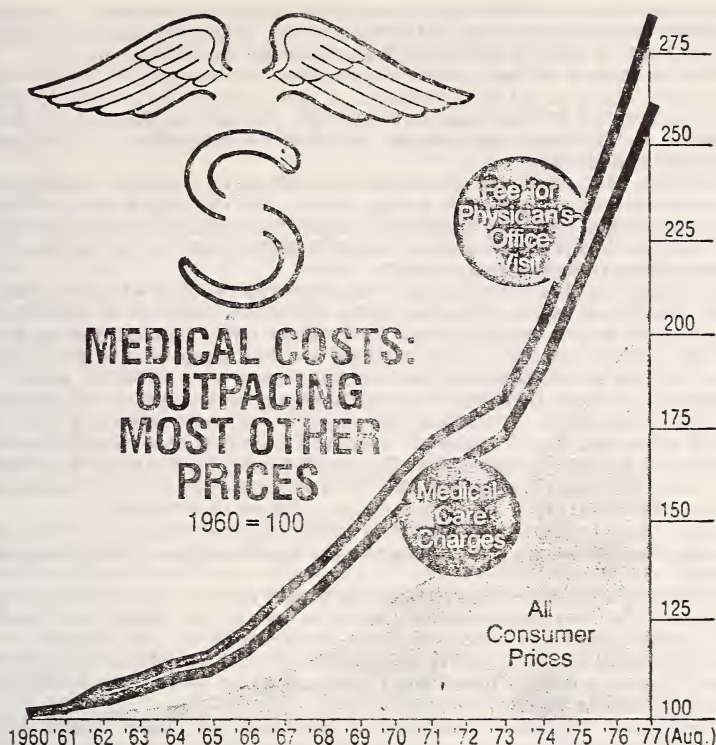
Yet, say health officials, it is none other than doctors themselves who are at the core of the cost crisis. Working under conflicting pressures from hospital administrators, the public, drug companies, insurance carriers and medical schools, it is the physician who makes the key decisions: He or she is the one who sends the patient to the hospital, orders the tests and performs the procedures.

Although physicians collect only 20 percent of all the money spent on health, according to HEW, they generate 70 percent of the total costs when bills paid for drugs, surgery, hospitalization and other medical procedures ordered by doctors are counted. Government planners estimate that each doctor is responsible for generating \$200,000 in medical costs a year, aside from charges for his own services.

Can doctors hold down rising costs? "Unfortunately, doctors don't think about the costs of what they're doing," says Dr. James G. Haughton, administrator of the Cook County public-hospital system in Illinois. "They are captives of their own technology, and unless we can control the doctors, we're in trouble."

At the center of this dilemma is the fundamental principle of medicine embodied in the Hippocratic oath which binds a physician to do everything in his or her power to treat the patient. Dr. Charles W. Thompson of Washington, D.C., speaks for many of his colleagues when he says: "Sure I use my judgment in ordering tests, but my job is to do what's best for Charlie Thompson's patients—and I don't give a damn how much it costs."

Can this principle be maintained in an era of high-priced technology? "This is a luxury we can no longer afford," replies Dr. Howard H. Hiatt, dean of the Harvard School of Public Health. "As we develop more and more practices that may be beneficial to the individual but not to the interests of society, we risk reaching a point where marginal gains to individuals threaten the welfare of the whole."



THUS in 17 years, medical costs have climbed about half again as fast as has the cost of living in general.

Source: U.S. Dept. of Labor

DOCTOR'S MONEY TREE

In addition to the physicians' role in the cost crisis, more and more accusations are being leveled that the profit motive has overtaken the physician's sense of public service—seriously diminishing his professional stature.

In an age of affluence, physicians have grown accustomed to high incomes: In 1975, general practitioners in solo practice averaged a net income of \$54,108 a year. Obstetrician-gynecologists who incorporated their practices averaged \$92,395 a year. Top specialists, particularly surgeons, are reported to earn more than \$250,000 a year.

According to *Medical Economics* and *Physician's Management*, doctors who incorporate or form partnerships make more money than solo practitioners; physicians in cities over 250,000 population make more money than those in smaller communities; specialists make more money than general practitioners. Orthopedists, dermatologists and urologists, for example, are at the top of the scale.

AMA officials point out that physicians are not the highest wage earners in our society. Their incomes, according to AMA statistics, compare with middle-level corporate executives. Moreover, a doctor must bear the heavy costs of medical education—now as high as \$12,500 tuition a year, according to the Association of American Medical Colleges. Many physicians don't begin private practice until age 30, and then with up to \$70,000 of debts and a malpractice-insurance premium that can run as high as \$20,000 a year.

Doctors also tend to work longer hours than most wage earners. According to *Medical Economics*, they average 60 hours a week; those with the higher incomes average 65 hours a week. Some physicians, however, work fewer hours.

It is in the process of becoming a doctor that the financial incentive begins, says Dr. John Cooper, AAMC president. A new student may want to go into general practice, but by the time he's halfway through medical school, he sees the prestige and financial advantages attached to specialties and switches to neurosurgery and the like.

Dr. Fitzhugh Mullan, a civil-rights leader, founder of a radical student-health group and leader of a house-staff union, states: "In the end, I went to medical school for extremely practical and really conservative reasons—the same reasons, more or less, for which my classmates went. Medicine could be counted on. It was a defined, needed, remunerative career."

An increasing number of physicians, to avoid the problem of getting liability insurance and the expense of setting up an office, are deciding to work for hospitals and other health organizations on a salary basis. Though not as high as incomes in private practice, such salaries are becoming competitive. Medical directors in large public hospitals, for example, draw over \$70,000 a year.

Hospital-based specialists such as pathologists, radiologist and anesthesiologists can go much higher. According to a recent report, medicare rules allow some specialists to receive a percentage of what the hospitals charge patients, which can boost their incomes considerably. The study found, for example, that pathologists on a straight salary make \$49,200. With a percentage contract, pathologists can increase their earnings $2\frac{1}{2}$ times—to an average of \$124,000.

Ironically, the introduction of medicare and medicaid—designed to bring physician services to the poor—has reinforced the profit motive within the medical profession.

For physicians who were already charging higher rates to more-affluent patients to compensate for treating so-called charity cases free of charge, medicaid and medicare often meant that incomes could double without any change to their practice. The latest count by HEW officials shows that an estimated 2,200 physicians and physician groups billed the Government for more than \$100,000 each for medicare patients alone.

Says Dr. George E. Pickett, president of the American Public Health Association: "I think doctors feel guilty and are defensive about how much money they make out of government programs."

Scandals involving such programs have come to light in recent years, further damaging the prestige of the medical profession. A series of investigations concluded that those doctors, nursing-home operators, laboratory owners and druggists who are crooked are defrauding taxpayers of more than \$1 billion a year.

This results from kickbacks on laboratory services, unnecessary tests, negligent care and outright fraud. One physician under medicaid billed the Government for performing six tonsillectomies on the same patient.

CONFLICT OVER MEDICAL QUALITY

With all the criticism of doctors over rising costs, is the profession practicing good medicine? On this question, physicians get a mixed report from both the public and the medical community. In general, most surveys show that the over-all quality of care in U.S. hospitals is good. Multidisciplinary teams at special centers such as intensive-care and burn units, chronic-pain clinics and rehabilitation institutions offer new hope to sufferers of the most devastating illnesses.

On the other side, study after study has led to charges of unnecessary surgery and hospitalization, misuse of drugs and radiation treatments and instances of incompetence.

The complicating factor in assessing the quality of medical service is this: Never have so many questions been raised so openly as now over what constitutes good medicine—and never have there been so many conflicting answers.

As Cleveland surgeon Dr. George Crile, Jr., explains: "We are standing at the end of an era in which patients supposed that physicians knew the answers to their problems. This supposition was based on the fact that, until recently, physicians tended to agree on the stylized answers that they gave. Few of the treatments they suggested were effective, but the patients did not know that, and the doctors agreed that the treatment prescribed was best."

With the increase in knowledge, there is less agreement on what is the best treatment. Twenty years ago, for example, all physicians agreed that digitalis was good for treating heart disease. Today, with the advent of surgical proce-

dures, there is disagreement on the place of anticoagulant-drug therapy for heart patients—or, for that matter, on the benefits of coronary-bypass surgery.

Not since the fledgling AMA exposed the shocking quality of care in hospitals in the early 1900s has the medical profession opened itself up to so much self-examination.

Surgeons, in particular, are the subject of numerous investigations. "The Study of Surgical Services in the United States," sponsored jointly by the American College of Surgeons and the American Surgical Association, found that of the 100,000 physicians who perform surgery in the U.S., only half have been certified by a specialty board.

More recently, a study of Veterans Administration hospitals showed that the quality of surgery was better in those affiliated with medical schools than in smaller community hospitals. It deemed surgical standards so poor in psychiatric institutions that surgery there should be stopped altogether.

Congressional investigations have suggested that more than 2 million unnecessary operations are performed in the U.S. a year at great cost and injury to the public. While that figure is hotly disputed by the profession, the problem of weighing the costs, risks and benefits of surgery remains.

"Among the luxuries of the United States and Canada, there are more surgeons and more operations per capita than in any other country," points out Dr. John P. Bunker of Stanford University School of Medicine. "Unfortunately, we haven't measured the quality-of-life benefits of medicine or surgery in any systematic way—nor do we know how to place a dollar value on such benefits."

OPERATIONS: CHARGES VARY

[Here is a general range of prevailing charges for 6 widely performed medical procedures. Physician fees shown are those the Government allowed across the country for operations covered by medicare during the year ended last July]

	Low	National average	High
Appendectomy.....	\$200	\$339	\$574
Gall bladder removal.....	300	523	1,085
Hernia repair.....	225	324	702
Prostate operation.....	350	656	1,100
Hysterectomy.....	400	623	1,000
Cataract operation.....	375	619	1,100

Note: Experts point out that actual charges may differ from these rates, depending on the individual case, doctor, and region involved. Figures are based on latest field reports to medicare bureau.

Source: U.S. Department of Health, Education, and Welfare.

Physician responsibility. One of the main shortcomings of physicians, critics charge, is failure to take the initiative and assure the public that basic standards are maintained throughout the profession.

Despite important studies that have produced charges of malpractice and substandard care, doctors individually and as a profession are still reluctant to crack down on errant or incompetent colleagues.

One problem is the fragmentation of the profession. Of the 100,000 physicians who perform surgery, for example, only 40,000 belong to the American College of Surgeons. Although this organization takes the lead in exposing shoddy surgical practices, it does not accept responsibility for the follow-up nor can it by law enforce any disciplinary action.

James Haug of ACS explains it this way: "We're a national education association. It's not the College's responsibility to police what goes on in every State. We set guidelines and make recommendations. But this is still a free-enterprise system, and we're not the keeper of all surgeons in the country."

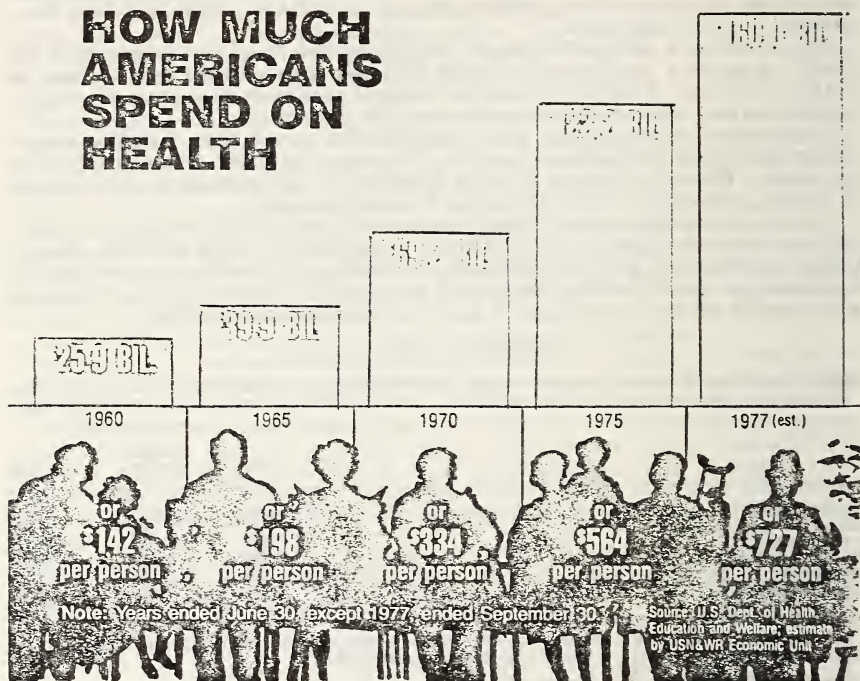
Sometimes the profession is so fragmented that information just doesn't get from one group to another. Example: For years it was known that the oral anti-diabetic drug phenformin can lead to fatal complications, and several diabetes clinics in major hospitals have discontinued its use. Yet, when it was finally banned recently as an "imminent hazard," physicians were still treating more than 300,000 patients with this drug.

THE PROBLEM PHYSICIAN

Can or should physicians police themselves? A number of medical cases that brought malpractice charges to doctors and tragedy for patients and families have forced the profession to come to grips with this issue.

Four years ago, an orthopedic surgeon in California admitted he was addicted to drugs and that he performed numerous unnecessary and sometimes negligent back operations. At the time of his trial, the surgeon was still practicing at a VA hospital.

Two years later, twin brothers in New York who shared a gynecological practice were found dead, victims of malnutrition and drug withdrawal as a result of their addiction to barbiturates.



The question asked of the medical profession is this: Why were these three doctors allowed to continue practice although their shortcomings were well known to their colleagues at the time?

Now that the courts have held the hospital liable for the negligence of its medical staff, physicians have taken a tougher stand on policing themselves. A number of States have passed stronger laws against medical misconduct and broadened the authority of licensing boards to discipline errant doctors.

As a result, discipline is being tightened. From 1971 to 1976, according to an AMA survey, disciplinary actions for fraud, incompetence and other offenses by doctors went up from 1,275 to 4,236. License revocations went up from 45 to 130, and the number of physicians on probation increased from 57 to 185. Still, this number is small compared with the total number of physicians.

While legal loopholes still make it difficult to take away a physician's license if he fights back, new laws encourage physicians to report malpractice among other members of the profession.

More than 20 States have passed legislation requiring medical societies, hospitals or individual physicians to report any misconduct to State officials. In several States a physician who fails to report misconduct can be held liable. In States where it is mandatory for a physician to report a colleague who is believed to be guilty of malpractice, the law also provides the reporting physician with immunity from civil liability.

On the federal level, the Professional Standards Review Organizations' legislation of 1972 has set up a peer-review system in hospitals that receive Government funds. Patient records are reviewed to make sure the treatment received is appropriate and meets a certain standard. The controversial PSRO program

has been slow to get started, but there are some signs that the peer-review process can improve the quality of care.

For example, a review of antibiotics in New Mexico in 1972 revealed that injections of tetracycline were wrongly prescribed in 90 percent of the cases. In response to this study, the use of this drug dropped significantly.

In addition, more than 30 States have established special programs to identify and rehabilitate physicians addicted to drugs or alcohol or suffering from mental illness.

Ever since the early 1900s, doctors have known that narcotic addiction was an occupational hazard. Until now, however, such frailties were kept secret and rarely was any action taken. Dr. LeClair Bissell, chief of Smithers Center at New York's Roosevelt Hospital, points out that an alcoholic physician is more likely to lose his license to drive than his license to practice.

Just how many doctors are involved is not known. The AMA estimates that 5 to 6 percent of the profession—or roughly 17,000 physicians nationwide—suffer from drug or alcohol addiction or mental illness. Statistics show that one medical-school graduating class of 100 students is needed just to replace physicians who commit suicide each year—at a rate more than double that of the U.S. population.

Most of the recent efforts to tighten medical standards focus on behavioral problems of physicians. In New York, where the main cause for disciplinary actions is drug-related offenses, a report to the State assembly says: "The more complicated subjects of concern which are most directly related to patient care, such as medical incompetence, negligence, overutilization of medical services, unnecessary surgery or hospitalization . . . are just not being dealt with under the current law, procedures and practices."

Sometimes the regulating system is ignored. An instance: In spite of the law requiring hospitals in New York to report any withdrawal or denial of physician privileges to State authorities, hospitals were failing to make such reports.

"What is happening instead," concludes the report, "is that problem physicians are being encouraged to resign before their privileges are curtailed, thus avoiding the reporting procedures and leaving the problem doctors free to go elsewhere unencumbered."

This situation is not unique to New York—which has just passed stricter medical-discipline legislation. Officials of the AMA say this is happening in every State. Even between States there are loopholes. Last spring a neurosurgeon who lost his license in New York got a license in Michigan.

MEDICINE'S COLLISION COURSE

Behind this and other vexing problems, a broader struggle is developing.

On one side is organized medicine, fighting for its independence. On the other is the Federal Government, demanding more control. Just as education during the civil rights era was the arena for Government intervention, health care has become a major focus of federal action in the 1970s.

With approval from the White House, HEW Secretary Joseph A. Califano, Jr., has criticized the medical profession, particularly for its role in the high cost of medicine.

"The Government . . . must play an increasing role in health care," Califano warned physicians at the last AMA meeting.

The profession is also under fire from the Federal Trade Commission on the ground of restricting competition. Already the Commission is recommending that doctors be permitted to advertise—a further erosion of physicians' professional traditions.

In organized medicine against Government inroads, speaks out against the "deadening weight of Government bureaucracy . . . a cancerous, relentless, mindless blob of a force."

With increasing Government involvement, the medical profession—which until now has regulated itself—finds it is being increasingly held accountable to different segments of society: the health official, the insurance carrier, the hospital board and the consumer.

With this loss of control over medical services, a sense of foreboding has settled over many in the profession. Some argue that they are already overregulated—by federal, State and local representatives, inspectors from the Joint Commission on Accreditation of Hospitals, insurance-company examiners, medical audit teams, professional organizations and consumer groups.

There is frustration over the many forms to fill out and the time spent on review committees. Says Chicago surgeon Franklin Lounsbury after 36 years of practice: "I think I've lived through the golden years of medicine."

Dr. William J. Barclay, editor of the *Journal of the American Medical Association*, is also pessimistic: "I see major changes ahead—more nurse practitioners treating patients, computers running tests, therapists doing the laying on of hands—in my darkest thoughts, I think doctors are becoming systems managers. Practicing medicine is no longer any fun."

"I'm not convinced," he adds, "that the best way to improve medicine is to remove physicians from the decision-making process."

The trouble, as many doctors see it at this time of transition, is that no unified voice speaks for all doctors—the professor of medicine, the practicing physician, the hospital's unionized house staff.

Most physicians owe their first loyalties to specialty organizations rather than the AMA. Once the spokesman for the profession, AMA now represents fewer than half the nation's physicians.

WHO GETS TODAY'S HEALTH DOLLAR	Hospitals	39.8¢
	Physicians	19.0¢
	Drugs	8.0¢
	Nursing homes	7.6¢
	Dentists	6.2¢
	Research, construction	6.0¢
	Other costs	13.4¢

Source: U.S. Dept. of Health, Education and Welfare

Following are excerpts from remarks by Joseph A. Califano, Jr., Secretary of Health, Education and Welfare, before a recent meeting of the American Medical Association in San Francisco:

The overarching problem of the health-care industry in America [is] the problem of runaway costs. . . . Not only is health-care spending devouring an ever-larger share of our gross national product, but under current projections:

Total health expenditures will double by 1980;

Hospital costs paid for by medicare and medicaid will double even sooner;

If unchecked, total hospital costs could reach 220 billion dollars by 1985;

Health costs is rising at a rate of 1½ times the rise in the cost of living.

This rapid inflation imperils the ability of uninsured people to get health care at all. It gobbles tax dollars at such a rate that they are not available for other public priorities. The Federal Government spends 12 cents of every taxpayer dollar on health care. The average American worker works one month each year to pay health-care costs.

Clearly the health-care industry as presently structured has become a problem for all of us: patients, physicians, providers of care, and public officials. Certainly we can understand why the American consumers and taxpayers—and more and more top executives of large corporations—are demanding that something be done.

But the AMA still knows its way around Capitol Hill. In the 1976 congressional

campaign, health ranked third after labor and business in the amount of contributions. Yet the AMA lost much of its clout in the losing battle against medicare and medicaid. Now, behind the rhetoric of confrontation, an effort toward co-operation is developing under Government pressure.

HEW's Hale Champion, in charge of drawing up the Administration's plan of national health insurance, makes this clear: "The medical profession is going to have to do this itself. We can introduce the right environment—incentives, for example, to go into primary care—but in the end the doctors are going to have to make these changes."

AHEAD FOR DOCTORS

Over the next decade, both health officials and physicians see the following trends:

Chipping away at the mystique of medicine will continue as efforts to unionize physicians and encourage public scrutiny of the profession take hold. With increasing Government involvement, the AMA seems likely to serve the profession more and more as a bargaining agent between physicians and the Government.

The economics of medicine are heading for major changes—with the Federal Trade Commission, for one, breaking into the profession's laissez-faire control of health care. Already the Government is encouraging competitive alternatives to the traditional fee-for-service system by promoting prepaid health plans such as the health-maintenance organizations.

Meanwhile, physicians are under pressure to make public more information about such matters as fees, types of services and professional standing, so that the consumer can "shop around" for medical care.

The ranks of the profession itself are expanding to include the greater use of paraprofessionals such as nurse practitioners and physician assistants. This is happening as the trend toward specialization continues to taper off.

Over all, medicine is shifting toward more preventive measures and self-care programs that stress changes in diet and behavior as an approach to promoting good health.

With all this, a new doctor-patient relationship may be developing, with patients asking more questions about the treatments they receive and taking more responsibility for their own health. "How to" books on self-care already are proliferating.

On an organizational level, consumers are taking a more active part in the politics of health. They sit on local health-planning boards—the Health Systems Agencies—to review the spending of funds on medical facilities.

Will all these trends bring improvements that so many physicians—and the public—would like to see? Increasingly, those in the profession and its critics on the outside conclude that improving the quality of medicine lies beyond technology and dollars.

What is called for, they find, is a basic reorientation of physicians' view of themselves and their place in a changing American society.

As the U.S. moves toward more government intervention in medicine, doctors will have to make fundamental decisions on how to adjust to this trend without yielding to bureaucratic excesses that could drown the profession and the public in red tape and party-line medical procedures. Yet, to gain public support in that task, doctors will have to put their own house in order—and keep it that way.

Within a new framework of these imperatives, the profession will be better able to cope with tomorrow's choices—between more of technology's hardware or restoring more to the human touch, for instance, and between the goals of living longer or living better.

These and countless other decisions, unforeseen by Hippocrates, are the challenges that U.S. medicine must meet in years to come.

Senator DOLE. I am wondering what the profession is doing to help get some control over these spiraling health costs.

Dr. HUNTER. There are several things we do, including utilization review, our involvement on a national basis and at the local level in the PSRO function which the Senate has brought before us as a profession, our medical audit.

Another significant thing the AMA has done is to create a commission on medical care. The results of the study of that commission are in the final editing stage now. Results will be available before the end

of this year. I think they will be of significant benefit to us as a profession and to you as Members of Congress.

Senator DOLE. What happens after they are published? Is it a voluntary effort now, or is it required to comply with any recommendations, to abide by any recommendations made?

Dr. HUNTER. If they become the policy of the association, and I believe, as a leader within that association, I shall make every effort to see that they do become policy of the association, we will make every effort to spread the knowledge of the content of this report to the physicians of this country and to see, through all of our organizational activities, that the recommendations are implemented.

We have no mandatory power. We only work through a voluntary system.

Senator DOLE. I do not want to keep coming back to one article. There are a lot of articles these days on health care costs, and I think there is a greater awareness of the need to contain those costs.

I have not read it carefully enough myself to have any views on it, but have you read the article in U.S. News or looked at it?

Dr. HUNTER. Not as yet, sir. I have heard of it, and it has been recommended to me for reading.

Senator DOLE. I think it is fairly well balanced. It does indicate that physicians themselves may have to lead us out of the wilderness when it comes to cost.

Dr. HUNTER. In some respects, we do act as the purchasing agents for our patients, and we have already asked, among other things, that the physician receive a copy of his patient's hospital bill so he will be aware of the charges that are made on that bill and the charges that directly affect what he has ordered and what might be necessary, what might be duplicative. In this way, we can make an effort to squeeze in on the total hospital costs of each hospitalized patient.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much for a very constructive statement, Dr. Hunter.

[The prepared statement of Dr. Hunter follows:]

STATEMENT OF AMERICAN MEDICAL ASSOCIATION PRESENTED BY
ROBERT B. HUNTER, M.D.

Mr. Chairman and Members of the Subcommittee. I am Robert B. Hunter, M.D., Chairman of the Board of Trustees of the American Medical Association, and I am in medical practice at Sedro Woolley, Washington. With me today in making the presentation of the American Medical Association on the important issue of cost containment is Harry N. Peterson, Director of our Department of Legislation.

Mr. Chairman, in these comments we will address the three important matters which we understand are the subject of this hearing. First is your own proposal for hospital cost containment. Another is S. 1391, the Hospital Cost Containment Act of 1977 as presently reported to the Senate Committee on Human Resources. The third item is H.R. 8423, amendments to the Medical End-Stage Renal Disease Program, a bill that has recently passed the House.

INTRODUCTION

As Congress is aware, available resources for health care are finite. It is therefore inevitable that difficult decisions will have to be made at some point with respect to how much of our resources can be allocated for health care services. Yet, we must counterbalance that choice with the recognition that limits will mean that not all persons can obtain all desirable medical care. When approaching the question of cost containment, we must keep in mind that the decisions made today cannot be quickly reversed ten years—or even a few years—down

the road. It takes time to build a system and it takes constant infusions of resources to maintain that health care system at a high level of quality. Decisions today will reverberate for years to come.

We must not lose sight of the fact that arbitrarily cutting costs will result in lessened quality of care. Some would argue that our system has excess capacity and sufficient slack to afford a tightening of the belt. This may very well be the case to some degree. Yet these conditions are, to some extent, also necessary to the workability and smooth functioning of the system and are indispensable to assuring access to quality patient care.

A decade ago the major concern in our society with respect to health care delivery was the question of access. To a large extent private, state, and federal programs have alleviated the problem of access to adequate health care for the majority of our citizens.

However, today we face another issue—the cost of providing these health care services. There is little question that health care costs are rising rapidly or that rising costs are a concern of all. We point out that rising health care costs are not the result of any single force. For example, there has been a tremendous increase in technological advancements in the provision of health care. With new advances, there is the need for increased sophistication in medical facilities and equipment and the need for more highly trained individuals to utilize the advances in technology. Inflation and sharp wage increases continually push costs higher. And of course, one can look at the infusion of patient care funds into the health care system, both through private insurance and through government resources such as the Medicare and Medicaid programs. Yet in the last analysis, the patient, when ill, wants and deserves only the best that our system can provide.

I would like to turn first to your most recent cost containment proposal, Mr. Chairman.

PROPOSAL OF SENATOR TALMADGE

It is our understanding that the proposal on which you have requested comment, Mr. Chairman, is not available in legislative language. We have reviewed the general descriptive material, and we will comment on several aspects, noting that your proposal is offered for purpose of discussion and reaction generally.

As we understand the proposal, there would be two general limitations on cost containment: one, an overall limit on hospital revenues for inpatient care, and the other, a special limitation on hospital reimbursement under Medicare and Medicaid. Within the inpatient hospital cost constraint provisions a division would be made between routine costs and ancillary costs. Limits on routine service revenue would be determined by: (1) grouping hospitals; (2) computing an average cost per diem; and (3) then comparing the per diem costs of each hospital with the group to the group average. Total amount allowable for routine costs would be equal to the per diem times the total inpatient days. While no absolute dollar limits would be imposed, amounts in excess of total allowable per diem are subject to penalty. However, as the program would be extended to encompass ancillary costs, "caps" on revenues for ancillary services would be computed. These limits would operate in much the same manner as the Administration's "cap" program.

State hospital regulatory activities could be accepted in lieu of the federal limitations where such state regulations apply to at least the same hospitals and services as the federal program and where the state limits hospital revenues, in the aggregate, to the same or less revenue as the federal plan.

Until the proposed amendments are presented in specific statutory language, it is necessary for us to address the proposed amendments in general terms.

One of the principal changes from S. 1470 is the delineation between computation of routine revenue limitations and ancillary revenue limitations discussed above. A further change would extend the per diem determinations to all hospital patients and not just to Medicare and Medicaid patients. Moreover, since the revenue limitation on ancillary services would operate to allow hospitals to retain only 50 percent of the costs when admissions exceeded 2 percent over the base year, we fear that this, like the Administration's proposal, would have the effect of discouraging an increase in otherwise needed patient services.

Mr. Chairman, there are many complexities inherent in this proposal. For instance, several factors affecting the per admission ancillary service allowance would have to be taken into consideration, such as wage increases in the locality and the determination of a newly designed national "market basket" index for goods used in connection with ancillary services. Apparently new limitations not specified would be imposed on Medicare and Medicaid expenditures.

While I recognize our comments are not detailed at this time, we would be happy to comment further when legislative language becomes available. We do

note that many of the provisions contained in these proposed amendments appear similar to or would incorporate provisions of S. 1470. In our testimony on S. 1470 before this Subcommittee we pointed out our concerns over the limitations that would be imposed, and, while we support appropriate programs for cost limitations, we urged at that time the cost containment program of S. 1470 should be initiated under an experimental, geographically localized, program prior to any nationwide application and commitment. We believe there would be merit in considering experimentation with any program developed under the proposed amendments.

The Committee is to be commended for these hearings to seek a public review of the potential ramifications of this involved program.

We will continue to study your proposal as new developments unfold, and would be happy to provide any assistance we can to your Committee.

S. 1391—THE HOSPITAL COST CONTAINMENT ACT

S. 1391, as approved by the Senate Human Resources Committee, would establish a federal program setting arbitrary limits on hospital inpatient revenue increases, placing a moratorium on capital expenditures (including certain medical equipment in physicians' offices), limiting aggregate capital expenditures to a nationally determined level (allocated by State) and modifying the Health Planning Law to allow, among other items, "decertification" authority to the state.

Hospital Cost Containment Program.

The bill, incorporating the basic program of the Administration, would require percentage "caps," as determined by the Secretary based on general economic conditions, on allowable inpatient revenue increases by all acute care hospitals. The "cap" limitations would not apply to federal hospitals, certain HMO hospitals, or, under certain conditions, to new or small hospitals. After the first year of operation of the program, the Secretary would establish a new "cap" which would take effect unless disapproved by either House of Congress.

Penalties in enforcement of the hospital cost containment program would be through the disallowance by the Social Security health programs of any payment in excess of the cost containment limits, and through the payment of a federal excise tax at the rate of 150 percent on any excess revenues above the limits either paid by a cost payor or received by a hospital. Exclusion of providers from further participation in Federal programs could be ordered by the Secretary.

The bill would provide for waivers from the federal program for hospitals located in States with cost containment programs that met specified criteria. A State presently having a cost containment program could receive a waiver only if it met (among the other criteria) a provision restricting revenue increases to 110 percent of the limit of the federal program and, at the option of the State, allowing wage pass-throughs for nonsupervisory personnel. A State conducting a hospital cost containment program at a later date would have to meet similar requirements, but pass-through for wages would be mandatory.

Many other detailed provisions are in the program. We would like to point out initially that the "transitional" provisions of the bill are on their face permanent since there is no termination date of the program in the absence of future Congressional action. The formula is self-executing and mandatory year after year. While the bill also calls for a report of "permanent" reforms, such a report would have no effect upon cost control provisions in the absence of Congressional action.

We believe that the proposed limitations on inpatient hospital revenues as are proposed are inappropriate. Artificial limitations, irrespective of how generous or how restrictive, are unrealistic. In order to provide an uninterrupted flow of quality hospital care which the American people demand, a hospital must keep pace with current technological advances. This often means the purchase of expensive equipment. This often also means the necessity to expand hospital services. No patient wishes to be admitted to a hospital which he believes is not a modern hospital. A reimbursement limitation on hospitals which does not allow increases reflecting true cost increases could have the effect of unfairly and inappropriately restricting increased expenditures by hospitals when those increases are necessary due to increased service, better equipment, or more highly skilled staff.

This legislation would in effect limit the physical plant and technological increases of any hospital by limiting revenues. We believe that such a limitation as proposed by S. 1391 would be quite detrimental to individual hospitals which seek

to remain in the mainstream of modern medical treatment and care. Such a limitation is also compounded when one considers the capital expenditure moratorium which the bill proposes.

The formula under the bill for determining revenue increases is based on inpatient hospital revenue per inpatient admission. The average reimbursement per admission and the average inpatient charges per admission could not increase over the base year by more than the allowable percentage as determined by the Secretary using a complex formula (estimated at 9 percent the first year). This formula would become completely uncertain following the first year when the Secretary would in effect use any method he developed subject only to Congressional disapproval.

The allowable increase would, however, be subject to modification through a "volume load factor." Increased hospital inpatient revenues under this bill would be limited to only one-half the average revenue per admission where the total admissions exceeded an allowable percentage increase in admissions. However an absolute limit on total revenue would apply. On the other hand, if the inpatient admissions decreased beyond certain limits, one-half the average revenue per admission would be deducted from the total revenue for each admission beyond that decrease limit.

We believe that the "cap", irrespective how it is determined, is manifestly unfair. It could in fact penalize efficient hospitals and reward inefficient hospitals. Furthermore, in our opinion it could have the effect of discouraging hospitals in communities from increasing their costs as a result of improving their services through desirable means such as seeking additional necessary medical or nursing personnel. A basic fault of the bill is that hospital revenue is fixed without proper relevance to total patient admissions. Thus the more admissions a hospital has above its base year, the more likely it is to be penalized. This in effect will penalize hospitals for providing needed expanded inpatient services by restricting payment to one-half of cost. There is an incentive not to provide otherwise needed services. Moreover, our fears of the arbitrary nature of the "cap" are not ameliorated by the provisions directing the Secretary to develop a new "cap" after the first year. We also question the propriety of the provision for a "legislative veto" of the Secretary's action.

Penalties under the bill include the 150 percent tax provision. Such a provision is manifestly offensive to the concept of fairness and should be stricken. The federal government should not seek to impose such a penalty upon hospitals or payors under the guise of a tax or any other method. If such a "tax" were applied, the result could impact adversely upon quality care of patients.

Exemptions under the bill would apply to certain hospitals, most noticeable of which are federal hospitals. Also certain HMO hospitals are exempt from the provisions. While we believe that the provisions of this bill should not be applicable to any hospital, we also believe that if limitations are to be applicable, they should be equally applicable to federal hospitals and to HMO hospitals.

Wage increases for non-supervisory personnel are exempted from the arbitrary revenue limits under the bill. While we do not advocate that wages should be subject to such an onerous bill, we question the reason for the exemption if in fact hospital costs are sought to be contained. One of the factors for rapid hospital increases in recent years has been the rapid increase in salaries and wages of non-supervisory personnel. Furthermore, the bill discriminates in its treatment and recognition of increases for supervisory and non-supervisory personnel.

We also note that this wage "exemption" would vary. Under the federal program, the exemption would be mandatory. Under a program administered by those few states presently having a State administered control program the wage pass-through would be optional. For states establishing a cost control program in the future, a wage pass-through would be mandatory. Why should there be such a differentiation?

We believe that S. 1391, with its proposal for a "cap" program on hospitals, should not be adopted.

Moratorium and Limitation on Hospital Capital Expenditures, and Decertification of Facilities.

The second major program of S. 1391 would impose a moratorium on capital expenditures in effect until September 30, 1979. During this time no capital expenditures for equipment or facilities to provide health care, directly or indirectly, could be made except in certain limited situations. A capital expenditure

would be an expenditure of \$150,000 or more, or one which changes the bad capacity or substantially changes the services of the facility. Included also would be physicians' medical equipment in his office.

Exceptions to the moratorium would generally apply to any equipment or facility approved by the State Planning Agency. Also exempted would be capital expenditures made by a physician or group of physicians for new construction for office facilities. However, any such expenditure for diagnostic or therapeutic equipment which in the aggregate totals in excess of \$150,000 would not be exempted and thus would be subject to certificate of need.

The bill would retain the Administration's annually proposed national capital expenditures limitation as allocated among the states; would adopt penalties for failure to comply with the moratorium of no less than twice the capital expenditure but not more than twice the aggregate operating revenues resulting from the expenditure; and would modify the health planning law by allowing the State health planning agency to "decertify" an existing institutional service as not needed and thus to treat the facility as if no certificate of need had been issued.

Inclusion of physicians' medical equipment expenditures, by imposition of a moratorium on capital expenditures or through extension of health planning review and approval, is both unjustified and unsupportable. As proposed, the \$150,000 limit would be for capital expenditures "in the aggregate" over a two-year period. Such a limitation would prove onerous, especially for physicians first opening a practice as well as for those desiring to modernize offices in order to assure continued quality patient care.

Mr. Chairman, we view this provision as being totally unrealistic. Consider, for instance, the deterrent effects such a provision would have upon the establishment of new practices, or the expansion or modernization of practices, in rural or other shortage areas. The planning law itself was not intended to cover physician office practice, nor should it now be extended to include such practices. Physicians' medical equipment should not be subjected to these provisions.

The capital expenditure limitations proposed under this bill are clear examples of federal control over the community. Mr. Chairman, the National Health Planning and Resources Development Act was originally presented as fostering local planning and local determination of local needs. The proposed bill, however, seeks to use the Planning Act as a vehicle for further refining federal control over local decision making.

We fear that such absolute limitations on the amount of capital expenditures would only benefit inefficient hospitals by preventing competition. Indeed, this total national limitation of \$2.5 billion is estimated as being only 50 percent of current levels of annual expenditures. While we support voluntary and responsible activity to assure that unnecessary capital expenditures are not made, we believe an arbitrary level for total national expenditures will have a serious and detrimental impact upon health care.

The decertification provisions are likewise inappropriate. Under the proposal it would be possible to disapprove an institution or service solely on the basis that a planning agency decided the institution or service was "inappropriate". Authority to decertify means the power to ration care. While dollars in the long run may be saved by the government, we question whether full access to quality medical care by individuals would in fact be paramount in decisions.

We question further the use of general revenues to subsidize the elimination of decertified services or facilities. The subsidy would apply to both for-profit and not-for-profit facilities. Moreover the limitation of such funds to compensate only for any outstanding debt creates an artificial distinction operating to the prejudice of institutions whose debt obligations have been successfully retired. Property rights are affected irrespective of whether an outstanding debt exists.

Mr. Chairman, it must be remembered that procurement of the newest technology, while expensive, is necessary if we are to maintain full access to quality care. It must also be remembered that adoption of arbitrary national limits is tantamount to a Congressional declaration that the most advanced technology will be available to only certain persons in the community.

We believe that the capital expenditure limitations and the decertification provisions of the bill should be stricken.

H.R. 8423—AMENDMENTS TO THE END-STAGE RENAL DISEASE PROGRAM

H.R. 8423, as passed by the House, would amend the present Medicare law to provide for increased coverage to persons having end-stage renal disease, for expansion of methods of reimbursement for physicians' and providers' services,

for an expansion of responsibility of renal disease networks and medical review boards, and for payments to donors.

The AMA supports several of these new provisions but believes others should be substantially modified.

Coverage under the Medicare end-stage disease program would be expanded by extending the period for receipt of benefits. We believe that current program coverage is unrealistic in that the length of coverage is too limited. Accordingly, an extension of the 12-month coverage period to 36 months (with continued additional support when required for renal failure) is appropriate, particularly since alternative coverage is not at present readily available.

Reimbursement for physicians' services under the ESRD program would be either on an individual or a periodic treatment basis, and would include payment on a comprehensive fee basis.

The American Medical Association has long supported a policy of physician reimbursement at usual, customary, or reasonable charges and believes that all physicians who seek reimbursement under Medicare Part B should be eligible for such reimbursement. An arbitrary classification of physician reimbursement under Medicare (already unfairly restricted) would be further restricted under H.R. 8423. Such arbitrary classifications run the risk of discouraging physicians from undertaking, or remaining active in, the treatment of patients with chronic renal disease. Physicians should be free to participate under all aspects of the Medicare program on an equal basis.

Home dialysis provisions of the bill would require home dialysis training as well as require home dialysis programs. The bill mandates that a majority of new patients being accepted for end-stage renal disease treatment should be in self-dialysis settings or be transplanted.

The American Medical Association supports the concept that a patient should be encouraged to self-dialyze at home when medical, psychological and social conditions warrant such home dialysis. However, it must be recognized that a high degree of personal motivation and a stable and supportive home environment are considered essential to successful home dialysis and that a "predetermined proportion" of patients that must be engaged in self-care dialysis should not be required.

Medical review board responsibility and renal disease networks would be expanded under the bill. The network organizations and the medical review board would be responsible for assessing the appropriateness of patients for proposed treatment procedures, not only in kidney disease treatment centers, but also for assuring that such facilities are maintaining an "appropriate proportion" of patients in self-dialysis training.

We believe, and must again emphasize, that the patient's treatment must be based on the individual patient's condition and need for treatment, and not on an arbitrarily designated percentage.

Kidney donors would receive Medicare payments under the bill. Because of the Medicare ESRD program and the need for patients to receive transplant, we believe that the medical services required by the kidney donor, an indispensable party for any kidney transplant, should also be viewed as an integral factor in any reimbursement scheme.

Non-physician reimbursement would be allowed through experiments to develop methods of reducing the cost of the end-stage renal disease program.

While the AMA concurs in the concept of experimental payments for services of nurses and dialysis technicians, we believe that such non-physician personnel should be limited to those individuals who render services to the extent recognized under State law or State regulatory mechanisms, who render services under the supervision and direction of a physician (whether or not such services are performed in the physician's office and whether or not at a place where the physician is physically present) and for whose service the physician bills.

Equipment subsidy and pilot program provisions of the bill are established and the AMA supports the provisions in the bill for equipment subsidy in pilot programs.

Studies of the ESRD program are also required under the bill. We support studies of the ESRD program, which could be beneficial in showing areas in which the high cost of end-stage renal disease programs are concentrated. Such studies, however, should be conducted for the entire program and not just on physician payment as proposed. We also believe consideration should be made for reimbursement to the physician on usual, customary or reasonable charges for providing services to the patient, irrespective where the patient is located or where the service is performed by the physician.

CONCLUSION

In conclusion, we urge that H.R. 8423 be adopted only after modifications reflecting our comments.

As to cost containment proposals we urge the Subcommittee to keep in mind that full access to quality care for those individuals needing health care service requires appropriate resources. Arbitrarily limiting resources—both physical and financial—affects not only access, but also quality.

The provisions of S. 1391 would in fact set undesirable absolutes on cost increases and capital expenditures. The bill would also extend unjustified and unwarranted health planning regulation over integral parts of physician's office practices and would establish undesirable "decertification" authority. These provisions should not be supported. We urge you and the members of the Subcommittee to consider very closely the long term potentially adverse effects on health care of S. 1391, and urge that the bill not be adopted.

Mr. Chairman, the number of bills on cost containment and variety of approaches indicate the wide differences of opinion and the complexities involved in creating a national program for hospital cost containment. The impact of any program could be far reaching with serious effects for health care delivery. No action should be taken without careful deliberations weighing all these ramifications.

Before closing, I would remind the Subcommittee that at our last appearance on the subject of cost containment, we informed you of the activities of our National Commission on the Cost of Medical Care. This Commission, with diversified membership, is nearing the completion of its extensive study and its report is expected soon. We will be pleased to make available to you their findings and recommendations when they are finalized, for consideration in your deliberations.

Mr. Chairman, we will be pleased to answer any questions you may have.

Senator TALMADGE. Our next witness is Mr. James Hacking, assistant legislative counsel, National Retired Teachers Association/American Association of Retired Persons; accompanied by Mr. Ralph W. Borsodi, economic consultant.

Is Mr. Hacking here?

His statement will be inserted in the record, then.

[The prepared statement of Mr. Hacking follows:]

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE
AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman: I am James M. Hacking, Assistant Legislative Counsel for the 12 million member National Retired Teachers Association/American Association of Retired Persons. With me is Ralph W. Borsodi, our economics consultant.

Our Associations are deeply troubled over the adverse economic trends in the health care industry and increasingly anxious over the inevitable consequences of those trends for our members and the elderly in general. We assume that we would not be all sitting here if we were not all satisfied that the nation's bill for hospitalization, an increasing share of which government at all levels is being called upon to meet, has been rising from year to year at inordinate and totally unacceptable rates. Certainly, other institutional costs and professional service charges in the industry have shown unsatisfactory trends, when compared to general price movements. But it is the escalating cost of hospitalization that truly shock the sensibilities.

Hospital costs have risen to such a degree that out-of-pocket expenses in nominal terms are now much higher for Medicare patients than they were when the program started. Only last month Secretary Califano announced a 16 percent increase in the Part A deductible. In 1970, it was \$52; beginning next year, it will be \$144. The Secretary also pointed out in a recent appearance before a House committee that the cost of an average hospital stay has increased from \$1,300 to \$1,400 since the Administration advanced its hospital cost containment initiative last February.

The consequences of the intractable and highly inflationary health care cost spiral for the elderly and for the programs upon which they depend for much of their needed access to health care services are clear and have been set forth by us repeatedly in appearances before other committees with jurisdiction over the Administration's cost containment proposal. Because of our fear of, and desire to

avoid these consequences, we have repeatedly proposed that the rate of increase in hospital costs and revenue be capped until some coordinated and effective long term solutions can be developed and implemented.

The question before us seems to be whether or not the cost of hospitalization can be restrained beginning in 1978 by a program of permanent remedies that would avoid the disruption and inequity that a temporary and arbitrary hospital cost containment program might entail.

Mr. Chairman, we have reviewed the description of your hospital cost containment program, as outlined in the Congressional Record for October 6. We assume that the acuteness of the hospital cost problem and the urgent need for a control program has induced the expansion of the scope of the hospital reimbursement sections of S. 1470, and the acceleration of the effective date of the contemplated routine and ancillary services revenue limit programs to July 1 of next year.

We are glad to see the addition of ancillary services to the containment effort. We are also pleased that all third party payers would be affected. But as we said with respect to S. 1470 on June 10th, we expect that the cost savings that would accrue from the implementation of the reforms in this alternative approach would be far too little (if there are any at all) and would come far too late for our Associations to consider it an adequate short-term remedy for the problem at hand. We did not consider S. 1470 and we do not consider this new package to be the kind of proposal that is going to be workable and effective in the short term. We do not for the moment believe that it would accrue anywhere near the cost savings that the Administration's original bill or that bill as modified by the Human Resources Committee would accrue.

If the program contemplated in this new alternative package were to be phased in over a period of 3 to 4 years, perhaps there would be time to establish uniform cost accounting procedures and accumulate the data base on which the success and effectiveness of the program ultimately depend. But, there is no time for that since the effective date of the program is mid-1978.

As far as we are concerned, the cost accounting procedures, the classification process, the averaging process, the cost savings incentives and the overall effectiveness of the controls that this proposal contemplates need to be tested through demonstration projects. If, instead, this program is applied, in an untested state, to hospitals on a nationwide basis and it fails to work, we will have lost a tremendous gamble and will find ourselves, some years from now, faced with an even bigger problem. That government bureaus can establish fair prices for products and services with the assistance of uniform accounting methods is a proposition that has not been proven. The National Recovery Administration established in the first term of Franklin Delano Roosevelt took this approach. Although this experiment in fair pricing was cut short by the intervention of the judiciary, it must be recognized that the great diversity in American industry, the tremendous costs of uniform accounting, the time lags involved in the feedback of information, and the difficulty in interpreting that information, makes the establishment of fair prices an enormously complex if not impossible task. Despite the aid that state-of-the-art budgetary techniques and computers would afford, our Associations have little faith in the workability or potential effectiveness of an exclusively regulatory approach to the problem of controlling costs in hospitals on a permanent basis.

Health care is already one of our most heavily regulated industries. Yet, despite that regulation and despite the fact that we are burdened with excessive health facilities in many areas, costs continue to escalate. We are of course aware that health facility planning laws have been enacted to deal with this economic curiosity. But, they have not had much effect thus far. It seems to us that the problem of escalating costs has been created because third party payers, including the government programs, compensate hospitals on a cost-plus basis with little restraint on their cost structures. If we have excess facilities in some areas, it would make sense for third party payers to favor the use of lower cost hospitals.

Our Associations find it curious that the Congress tends to rely, almost exclusively on regulation to control the cost of health care. This latest control package attests to that. Under its program, hospitals would be grouped. Those whose routine costs are below the average would be rewarded; those whose routine costs were far above average would be penalized.

The problem with this scheme is that the upward limits would apply only to those hospitals within a group whose costs inflate far faster than those of a group as a whole. Therefore, if hospitals within a group continue to have cost rising far in excess of the general rate of inflation in the economy, there is really no limit and no savings.

We urge this Subcommittee to recognize that budgets tend to rise unless those who control know as much about the expenditures as those who spend. Our Associations believe that budgeting techniques have serious limitations for controlling the health care industry both with respect to operating expenditures and capital expenditures. We would hope that any permanent reform program that is developed to deal with the existing causes of health care cost inflation would not rely exclusively on regulation and budget controls. To the extent possible, any such reform program should rely on the pricing system—a tried and demonstrably effective means for containing costs. If Medicare dropped its allowable cost formula and became a charge payer for the bulk of the ordinary care in hospitals, a basis of competition would be introduced. While physicians would no longer be completely free to place their patients in the most expensive hospital town, we are sure they could learn to live with that. Additional competition could be introduced into the hospital sector by converting the insurance payers from cost reimburses to charge reimburses for common treatment. It is not in the public interest that the insurance industry reimburse hospitals, particularly where there is a surplus of beds available, without regard to the laws of economics. The better run, more efficient and less costly hospital should get the business.

While we are on the subject of permanent reform and the fostering of free market forces to contain the costs of health care, we have a complementary approach to suggest—the fostering of product competition. The promotion of health maintenance organizations, intermediate and long term care facilities, community health center, smaller clinics of all kinds, ambulatory surgical centers and home health care should tend to lower costs by creating alternatives to highly specialized care in the acute care hospital. We recognize that there never will be an orderly, competitive market for health care. We also recognize that regulation in the health care sector is a factor of life. It is likely to increase rather than decrease. But we suggest that the fostering of competition, including product competition and the placing of greater reliance on the pricing system will greatly enhance our ability to control rising costs and greatly reduce the burden, that, in the absence of these things, must inevitably fall on the regulators.

The moment of truth has arrived. The Federal Government must face the fact that regulating the health care industry as it is presently structured and compensated is likely to yield very little return for the immense effort involved. If we continue to follow the trend toward increased but still ineffective regulation and rely upon it as the sole means of controlling the cost of a national health program, we are going to find that the government will end up picking up the full tab for whatever bill the industry presents.

As you may gather from my remarks, our Associations are unwilling to endorse regulation as the sole, permanent remedy for the problem of health care cost inflation. Because we think more time is required to develop permanent remedies, our Associations have endorsed the Administration's hospital cost containment program. Despite all the bad things that can be said about a tax-paying controls program, we consider it the only potentially effective instrument for achieving significant cost savings quickly and arresting the inflationary cost spiral for a while. The one thing that a controls program such as is contemplated in the Administration's package can do is to buy time—time to explore some alternatives to ever increasing government regulation and time to develop and perfect to the point of optimal effectiveness, those regulatory programs that must be retained. Because we feel that the Administration's hospital cost containment proposal as modified by the Committee on Human Resources, would achieve significant savings in the short term and buy us the time we feel is necessary to consider and test permanent remedies, we urge this Subcommittee to set aside its work on a permanent reforms program and take up the Administration's bill. The sooner it is enacted, the sooner we can get back to the subject of permanent reform.

Senator TALMADGE. The next witness is Mr. Robert G. McCune, manager, Radiation Imaging Products Division, National Electrical Manufacturers Association; accompanied by Walter Nemasik, counsel.

Mr. McCune, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF ROBERT G. McCUNE, MANAGER, RADIATION IMAGING PRODUCTS DIVISION, NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION, ACCOMPANIED BY WALTER NIEMASIK, COUNSEL

Mr. McCUNE. Thank you, Mr. Chairman.

Our intent this morning is to address a few comments that are contained in our formal statement.

The majority of manufacturers of conventional medical and dental X-ray, computed tomography, diagnostic ultrasound, and nuclear imaging medical equipment are participating members of this industry group. As an industry trade group, we, too, are concerned with the problems associated with health care in the United States.

We are against the excessive use of any component of the health care systems, whether it be drugs, survey, equipment or doctor's services—but we are for quality medical care. We are against imposing arbitrary control on the doctor's skill in diagnosing and treating disease—but we are for encouraging these procedures to be appropriate and cost effective.

Therefore, we believe that the issue is one of achieving a proper balance between the supply and demand for quality health care at the local level, with reasonable and acceptable cost the result of this balance.

We believe that S. 1470, the "Medicare and Medicaid Administrative and Reimbursement Reform Act," as expanded with hospital cost provisions, provides incentives to achieve cost savings, is constructive and deserves public support. S. 1470 would impose on hospitals the strict economics of the marketplace.

The thrust of cost containment should be to encourage cost consciousness throughout the system through incentives and not discourage cost-effective capital investment in medically superior technology. Therefore, section 4, Federal participation in hospital capital expenditures, of S. 1470 properly suggests that the existing planning and regulatory system to control capital expenditures, with some refinement, is capable of functioning effectively.

We would, however, recommend that the definition of a capital expenditures for purposes of section 4, contained in section 4, paragraph (d), be modified by inserting "which (1) exceeds \$150,000," in place of "which (1) exceeds \$100,000."

In supporting S. 1470, we believe that this legislation will:

Hold down capital investment by encouraging greater emphasis on cost effectiveness and purchase based on need; encourage hospitals, doctors, and patients to utilize more economical outpatient facilities and to increase the emphasis on cost effectiveness in selecting diagnostic and treatment methods; and encourage the equitable distribution of medical facilities and equipment, thereby enhancing the overall quality of health care.

We urge that during this committee's deliberations of the other pending proposal on hospital cost containment S. 1391, you consider carefully the detrimental impact of title II of this bill—"Moratorium

on Acquisition of New Health Care Equipment and Facilities," on the quality of medical care in this country.

This section of S. 1391 would impose a moratorium on hospital capital expenditures of \$150,000 or more unless expressly exempted. In order to be eligible for such an exemption, a State would (1) need a State health planning and development agency designated pursuant to section 1521 of the National Health Planning and Resources Act of 1974; (2) have to administer a certificate of need program satisfactory to the Secretary pursuant to section 1523(a)(4), or is the designated planning agency pursuant to an agreement with the Secretary under section 1122 of the Social Security Act; and (3) have a State medical facilities plan which is satisfactory to the Secretary under section 1603(a).

Our industry agrees and supports these necessary requirements for approval of capital expenditures. However, under present circumstances there is no State presently able to meet such requirements due to the nonexistence of all necessary HEW national guidelines for health planning. Further, there is no apparent firm predictable date by which the States will have made available to them such policy guidelines in order to completely meet the requirements for full designation by HEW under title XV of the Public Health Service Act, and thereby qualify for an exemption. Consequently, title II of S. 1391 has the force of a de facto moratorium for an extended period of time.

We would also point out that in one of the House of Representatives hospital cost containment bills, H.R. 6575, presently in markup by the Interstate and Foreign Commerce Subcommittee on Health and Environment, there is a further element of major impact on the moratorium issue. New language in H.R. 6575 defines major medical equipment as medical equipment in excess of \$150,000 or which the Secretary designates by regulation for the purpose of having acquisition of it subject to certificate of need review.

It is our understanding that this would mean that the Secretary of HEW would have the authority to require medical equipment under \$150,000 to meet certificate of need regulations set forth in H.R. 6575, thereby resulting in a moratorium indefinite in time, on the acquisition of new health care equipment, regardless of cost.

Another concern we have with title II of S. 1391 is the proposed limit of \$2,500 million on all hospital capital expenditures for all 50 States, the District of Columbia, and Puerto Rico.

HEW has stated this will reduce aggregate capital spending by more than 50 percent in the first year. Based on this statement, you would conclude that capital expenditures for 1977 were \$5 billion. However, there are creditable sources that view the \$2.5 billion as representing only about one-third of estimated 1977 capital expenditures (\$7.5 billion) in the hospital industry.

It is also possible then to conclude that capital expenditures available to hospitals in 1978 will be considerably less than 50 percent of the total expenditures of 1977. This would seem unquestionably severe and highly arbitrary and could very well have an undermining effect on the quality of medical care in this country.

We would suggest that if the certificate of need process functions properly, local hospital capital needs will be fairly evaluated, ap-

proved when local conditions necessitate, resulting cost savings will be achieved, and all without the need for such a proposed artificial limitation.

As manufacturers of medical technology equipment, let me describe what we believe to be the potential impact of the de facto moratorium and the \$2.5 billion capital ceiling on a technological industry such as ours, and then offer some views on the possible impact of this moratorium and ceiling on the health care of the people of this country.

First, we feel there is a real possibility of an adverse effect on continued progress in medical research. Presently there is approximately \$2 billion of the total estimated \$5 billion invested annually on medical research and development in the United States that is spent by the private sector.

This money is expended on the hopeful realization of achieving a reasonable return on investment. An environment of legislated artificial limitations on the development and use of cost-effective and medically superior new technology would force a critical review of every medical technology type company's research and development budget and project allocation levels.

Next, there would be required by necessity an economic review of the impact of such a legislated moratorium and fixed capital expenditure ceiling in terms of employment levels and plant equipment utilization. Certainly such ramifications cannot be accurately assessed at this time, but there is no question of the reality of some layoffs of scientific, technical and manufacturing personnel that would be required along with the idling of plant and production equipment.

In examining the possible impact of a de facto moratorium a proposed artificial limitation and fixed capital equipment ceiling on the health care of the people of this country, we think that at a minimum it is reasonable to conclude:

That less effective medical technologies will be locked in place;

It will inhibit the medical practitioner's concern and involvement in advancing new techniques for improving patient diagnosis and treatment;

Waiting periods for patient access to in-place medical equipment will increase;

The opportunity for growth of improved and more economical outpatient treatment facilities will be slowed.

In closing, let me say that we believe that the Congress can act now to control health care costs effectively by (a) building on the existing regulatory system of section 1122 and Public Law 93-641 with an improved certificate of need review process and the immediate promulgation of reasonable guidelines in national health planning; and (b) encouraging greater cost consciousness in hospital management, as proposed in S. 1470, "Medicare-Medicaid Administrative and Reimbursement Reform Act."

Senator TALMADGE. Thank you, Mr. McCune. How many members are there in your association?

Mr. McCUNE. Fifty, sir.

Senator TALMADGE. I notice in your statement that the majority of manufacturers of conventional medical and dental X-ray, computed tomography, diagnostic ultrasound and medical equipment are participating members in this industry.

What is a computed tomography?

Mr. McCUNE. It is best known as the CAT scanner.

Senator TALMADGE. What exactly is diagnostic ultrasound and nuclear imaging medical equipment?

Mr. McCUNE. Diagnostic ultrasound as contrasted with commercial use of ultrasound is a medical technique used in fetal monitoring or pregnant women. It is also used in heart diagnosis and treatment planning. It is somewhat similar to the ASW doppler system.

Senator TALMADGE. What is nuclear imaging medical equipment?

Mr. McCUNE. This is what we refer to as a scintillation camera where contrast materials are introduced into the body and tracked by this nuclear scanner.

Senator TALMADGE. The reason I asked those questions, as you probably know, I am just a country lawyer and farmer, and all of those terms are a little new to me. I presume the technology in this field advances extremely rapidly?

Mr. McCUNE. Five years ago, the Congress of the United States had some oversight hearings expressing concern because of the lack of progress in diagnostic ultrasound in the United States where it was being steadily moved ahead in Western Europe, for example, and a study was undertaken as to why it has not progressed here. Yes, I think technology falls into that category, however, X-ray is almost 100 years old.

Senator TALMADGE. Was this country preeminent in the development of the sophisticated medical equipment of that type?

Mr. McCUNE. We are today.

Senator TALMADGE. Who would be the next-ranking country to us? The Germans, the Japanese?

Mr. McCUNE. I have some companies from Germany, the Netherlands, and England. I would have to be careful. I would say any of these three countries could be in that situation.

Senator TALMADGE. Do you think that a cap would be any threat to the advance of that technology?

Mr. McCUNE. We do, sir.

Senator TALMADGE. Thank you very much. I appreciate your contribution to our deliberations.

[The prepared statement of Mr. McCune follows:]

STATEMENT OF ROBERT G. McCUNE ON BEHALF OF THE RADIATION IMAGING PRODUCTS DIVISION, NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION

I am Robert G. McCune and I am appearing here today as the representative of the Radiation Imaging Products Division of the National Electrical Manufacturers Association. With me is Mr. Walter Niemasik, NEMA counsel. We appreciate the opportunity to be here in order to present our testimony.

The majority of manufacturers of conventional medical and dental X-ray, computed tomography, diagnostic ultrasound and nuclear imaging medical equipment are participating members of this industry group. As an industry trade group, we too are concerned with the problems associated with health care in the United States. We are against the excessive use of any component of the health care system, whether it be drugs, surgery, equipment or doctor's services—but we are for quality medical care. We are against imposing arbitrary control on the doctor's skill in diagnosing and treating disease—but we are for encouraging these procedures to be appropriate and cost-effective. Therefore, we believe that the issue is one of achieving a proper balance between the supply and demand for quality health care at the local level, with reasonable and acceptable cost the result of this balance.

In my brief comments this morning I would like to share with your our industry's beliefs and concerns that deal with this complex legislative process in the examination of the problem of health care in our country.

We believe that S. 1470, the "Medicare and Medicaid Administrative and Reimbursement Reform Act," as expanded with hospital cost provisions, provides incentives to achieve cost savings, is constructive and deserves public support. S. 1470 would impose on hospitals the strict economics of the market place. It provides a sound basis on which hospital managers can manage. It forces the question: Given its medical necessity, is a proposed investment economically effective in controlling hospital costs and saving patients money?

The thrust of cost containment should be to encourage cost consciousness throughout the system through incentives and not discourage cost-effective capital investment in medically superior technology. Therefore Section 4, Federal Participation in Hospital Capital Expenditures, of S. 1470, properly suggests that the existing planning and regulatory system to control capital expenditures, with some refinement, is capable of functioning effectively.

We would, however, recommend that the definition of a "capital expenditure" for purposes of Section 4, contained in Section 4, paragraph (d), be modified by inserting "which (1) exceeds \$150,000," in place of "which (1) exceeds \$100,000." This recommendation is based on the view that since 1972 when Congress enacted Public Law 92-603 (Social Security Amendments of 1972), which included Section 1122, the type of lower cost medical equipment envisioned to be excluded from the certificate of need process in many cases now exceeds \$100,000 due to cost escalation over the last 5 years. The \$150,000 level would also be consistent with the proposed level of the several other hospital cost containment bills.

In supporting S. 1470, we believe that this legislation will:

Hold down capital investments by encouraging greater emphasis on cost effectiveness and purchase based on need:

Encourage hospitals, doctors and patients to utilize more economical outpatient facilities and to increase the emphasis on cost effectiveness in selecting diagnostic and treatment methods;

Encourage the equitable distribution of medical facilities and equipment, thereby enhancing the overall quality of health care.

Turning now to some concerns. We urge that during this Committee's deliberations of the other pending proposal on hospital cost containment, S. 1391, you consider carefully the detrimental impact of Title II of this bill—"Moratorium on Acquisition of New Health Care Equipment and Facilities," on the quality of medical care in this country.

This section of S. 1391 would impose a moratorium on hospital capital expenditures of \$150,000 or more unless expressly exempted. In order to be eligible for such an exemption, a State would (1) need a State health planning and development agency designated pursuant to Section 1521 of the National Health Planning and Resources Act of 1974; (2) have to administer a certificate of need program satisfactory to the Secretary pursuant to Section 1523(a) (4), or is the designated planning agency pursuant to an agreement with the Secretary under Section 1122 of the Social Security Act; and (3) have a State medical facilities plan which is satisfactory to the Secretary under Section 1603(a).

Our industry agrees and supports these necessary requirements for approval of capital expenditures. However, under present circumstances there is no State presently able to meet such requirements due to the non-existence of all necessary HEW national guidelines for health planning. Further, there is no apparent firm predictable date by which the States will have made available to them such policy guidelines in order to completely meet the requirements for full designation by HEW under Title XV of the Public Health Service Act, and thereby qualify for an exemption. Consequently, Title II of S. 1391 has the force of a de facto moratorium for an extended period of time.

We would also point out that in one of the House of Representatives hospital cost containment bills, H.R. 6575, presently in markup by the Interstate and Foreign Commerce's Subcommittee on Health and the Environment, there are similar requirements to those in Title II of S. 1391 for States to achieve full designation under Title XV of the Public Health Service Act. But here again there exists the question of when will HEW's national guidelines for health planning be available to States in order for them to achieve full designation. And again the result is a de facto moratorium.

Moreover, H.R. 6575, as presently drafted, contains a further element of major impact on the moratorium issue. New language in H.R. 6575 defines major medi-

cal equipment as medical equipment in excess of \$150,000, or which the Secretary designates by regulation for the purpose of having acquisition of it subject to certificate of need review. It is our understanding that this would mean that the Secretary of HEW would have the authority to require medical equipment under \$150,000 to meet certificate of need regulations set forth in H.R. 6575, thereby resulting in a moratorium, indefinite in time, on the acquisition of new health care equipment, regardless of cost.

Another concern we have with Title II of S. 1391, is the proposed limit of \$2,500 million on all hospital capital expenditures for all 50 States, the District of Columbia, and Puerto Rico.

HEW has stated this will reduce aggregate capital spending by more than 50 percent in the first year. Based on this statement, you would conclude that capital expenditures for 1977 were \$5 billion. However, there are creditable sources that view the \$2.5 billion as representing only about one-third of estimated 1977 capital expenditures (\$7.5 billion) in the hospital industry. It is also possible then to conclude that capital expenditures available to hospitals in 1978 will be considerably less than 50 percent of the total expenditures of 1977. This would seem unquestionably severe and highly arbitrary and could very well have an undermining effect on the quality of medical care in this country.

We would suggest that if the certificate of need process functions properly, local hospital capital needs will be fairly evaluated, approved when local conditions necessitate, resulting cost savings will be achieved, and all without the need for such a proposed artificial limitation.

It is also interesting to note that in S. 1391 and all of the other proposed hospital cost containment bills, in the sections requiring the Secretary of HEW to submit to Congress at some early date a plan with his recommendations for permanent reform in the delivery and financing of health care and that will replace Title I of those bills, there is no reference to further attention to or review of Title II on limitation of capital expenditures. Are we to conclude that the proposed HEW plan for capital expenditure limitation is so well perceived that it will work perfectly, permanently, and professionally?

As manufacturers of medical technology equipment, let me describe what we believe to be the potential impact of the de facto moratorium and the \$2.5 billion capital ceiling on a technological industry such as ours, and then offer some views on the possible impact of this moratorium and ceiling on the health care of the people of this country.

First, we feel there is a real possibility of an adverse effect on continued progress in medical research. Presently there is approximately \$2 billion of the total estimated \$5 billion invested annually on medical research and development in the United States that is spent by the private sector. This money is expended on the hopeful realization of achieving a reasonable return on investment. An environment of legislated artificial limitations on the deployment and use of cost effective and medically superior new technology would force a critical review of every medical technology type company's research and development budget and project allocation levels.

Next, there would be required by necessity an economic review of the impact of such a legislated moratorium and fixed capital expenditure ceiling in terms of employment levels and plant equipment utilization. Certainly such ramifications cannot be accurately assessed at this time, but there is no question of the reality of some layoffs of scientific, technical and manufacturing personnel that would be required along with the idling of plant and production equipment.

In examining the possible impact of a de facto moratorium and fixed capital equipment ceiling on the health care of the people of this country, we think that at a minimum it is reasonable to conclude:

That less effective medical technologies will be locked in place;

It will inhibit the medical practitioner's concern and involvement in advancing new techniques for improving patient diagnosis and treatment;

Waiting periods for patient access to in-place medical equipment will increase;

The opportunity for growth of improved and more economical outpatient treatment facilities will be slowed.

Perhaps the concern we feel can best be summed up by quoting the words of a noted British scientist spoken some years ago: "In the big matters in which new scientific knowledge and technology are the major component . . . wise decisions for today cannot be safely taken unless we realize that those same decisions determine the shape of tomorrow and the day after."

In closing let me say that we believe that the Congress can act now to control health care costs effectively by (a) building on the existing regulatory system of Section 1122 and Pub. L. 93-641 with an improved certificate of need review process and the immediate promulgation of reasonable guidelines in national health planning; and (b) encouraging greater cost consciousness in hospital management, as proposed in S. 1470, "Medicare-Medicaid Administrative and Reimbursement Reform Act."

Thank you.

Senator TALMADGE. The subcommittee will stand in recess until Friday, October 21, at 8 a.m.

[Whereupon, at 9:55 a.m. the subcommittee recessed to reconvene at 8 a.m. on Friday, October 21, 1977.]

HOSPITAL COST CONTAINMENT AND END STAGE RENAL DISEASE PROGRAM

FRIDAY, OCTOBER 21, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 8 a.m. in room 1114, Dirksen Senate Office Building, Hon. Herman Talmadge—chairman of the subcommittee—presiding.

Present: Senators Talmadge and Dole.

Senator TALMADGE. The subcommittee will please come to order.

First, I want to insert into the record a letter dated October 12, 1977, addressed to me as chairman of the Subcommittee on Health of the Senate Finance Committee from Congressman Dan Rostenkowski, chairman of the Subcommittee on Health of the Ways and Means Committee, and my response thereto.

[The material referred to follows:]

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C., October 12, 1977.

HON. HERMAN E. TALMADGE,
*Chairman, Subcommittee on Health,
Senate Committee on Finance, Washington, D.C.*

DEAR MR. CHAIRMAN: As your Subcommittee prepares its agenda for the remaining weeks of this session, I would like to strongly urge your prompt consideration of H.R. 8423, the renal disease bill which Congressman Vanik and I introduced and which has been unanimously approved by the House.

As you know, our Subcommittee on Health devoted considerable time and effort to the development of this legislation in the firm conviction that it is vital to the continuing effectiveness and fiscal stability of the renal disease program. It is my belief that unless something is done very soon to reverse the alarming decline in the proportion of patients dialyzing at home and to introduce restraints on the steadily rising cost of the program, there is a real danger that the fiscal integrity of the program will be jeopardized. Moreover, there is the further danger that the program will create a renal disease population unnecessarily and undesirably dependent on institutional care if appropriate steps are not taken immediately to provide incentives for the use of self-dialysis.

I am confident that consideration by your Subcommittee will confirm these conclusions. I believe also that any improvements in the bill that you may find appropriate can be readily made. I hope, therefore, that you can agree on the need for immediate consideration of this bill so that we can achieve timely action by both Houses of Congress during this session.

With warm regards, I am

Sincerely yours,

DAN ROSTENKOWSKI, *Chairman.*

OCTOBER 25, 1977.

Hon. DAN ROSTENKOWSKI,
Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Thank you for your recent letter urging prompt consideration of H.R. 8423.

As you may know, the Subcommittee on Health of the Committee on Finance completed hearings on H.R. 8423 on Friday, October 21.

I see no reason why we can't move in timely fashion on your bill. Hopefully, we can move to Committee mark-up the latter part of this week or early next week.

With every good wish, I am,

Sincerely,

HERMAN E. TALMADGE,
Chairman, Subcommittee on Health.

Senator TALMADGE. Today, we conclude 3 days of hearings on hospital cost containment proposals and H.R. 8423, a House-passed bill intended to improve the medicare program for people who have suffered kidney failure.

Most of the previous witnesses concentrated on the hospital cost legislation. This morning, most of the witnesses will concentrate on the kidney program.

Medicare now pays out some \$600 million a year for treatment of kidney patients. There is a concern that a substantially greater proportion of patients can undertake home dialysis, and actually do so. According to social security's experience, home dialysis is significantly less costly than its alternatives.

We look forward to informed discussions of these issues.

Our first witness this morning is the Health Insurance Association of America, which will focus on the hospital cost containment bill.

If you gentlemen will come forward, we will proceed.

The full Finance Committee meets this morning in markup to report out a bill relating to social security financing, so witnesses must restrict their testimony to the minimum of time, 10 minutes maximum, and we must proceed as rapidly as possible in order that the full Finance Committee can meet at 10 a.m. on this very important social security financing measure.

Mr. Simons, you may insert your full statement in the record and summarize it as quickly as possible, please.

STATEMENT OF THOMAS C. SIMONS, EXECUTIVE VICE PRESIDENT, CONNECTICUT GENERAL LIFE INSURANCE CO., AND HENRY A. DI PRETE, SECOND VICE PRESIDENT, JOHN HANCOCK MUTUAL LIFE INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. SIMONS. Thank you, Senator.

My name is Thomas Simons, executive vice president of the Connecticut General Life Insurance Co. With me is Henry DiPrete, second vice president of the John Hancock Insurance Co. We appear today on behalf of the Health Insurance Association of America.

I want to thank you for the opportunity to present our comments on the proposals currently pending before your committee on hospital

cost containment. These proposals include S. 1391, as reported by the Senate Human Resources Committee and the expanded version of S. 1470, the Medicare and Medicaid Administrative and Reimbursement Reform Act.

Before discussing the two proposals, I want to reiterate the position of the Health Insurance Association of America on the issue of health care cost containment.

The companies represented by HIAA currently provide health insurance protection for over 100 million Americans. Consequently, these companies are intimately concerned with the costs of this country's health care delivery system which in large part is paid for by our insurers.

The rapid escalation of costs during the last several years has spread across the full spectrum of health services, with particular impact on the costs of hospital care. Many factors have contributed to this cost escalation: the fragmented nature of the delivery system, the cost-inducing tendencies of fee-for-service and cost-plus reimbursement mechanisms, the growth of third party reimbursement systems which shield the public from the impact of costs, the development of new technology, and the nature of medical education and licensing.

Because of these and other factors, the normal economic forces of the marketplace do not operate to restrain supply and demand and they have accelerated unchecked. This is a condition that cannot be sustained.

We believe, however, that these objectives can best be accomplished by a strong system of State prospective budget review agencies operating under simple but reasonable Federal guidelines that assure equity to all payors. We believe that S. 1470, as proposed, goes too far toward creating a single, and rather complex, permanent system of Federal controls and not far enough in terms of using State government.

Adding strong incentives for the establishment of State commissions as are provided in S. 1391 would substantially improve S. 1470. We favor State programs because we believe that hospital cost control will be more effective and equitable if operated at a level of government closer to the source.

No single national formula can adequately anticipate all of the exigencies and idiosyncrasies of a very complex delivery system. The Federal program should set policy and performance guidelines within which State programs will function and it should establish control and audit processes. The States should tailor their programs to consider factors unique to their individual situations.

Moreover, obviously, health planning and utilization review must be closely integrated with hospital cost control. Since health planning and utilization review both operate at the State level, improved coordination and mutual strengthening would result from having budget review and rate approval operate at the State level, also.

At its meeting in Detroit on September 8, 1977, the National Governors' Conference adopted a policy that parallels the position that I have just stated. I would like to include a copy of that statement as a part of our testimony.

Senator TALMADGE. Without objection, it will be included.

[The material to be furnished follows:]

POLICY STATEMENT OF THE NATIONAL GOVERNORS' CONFERENCE ADOPTED IN DETROIT
SEPTEMBER 8, 1977

NEW MEDICAL CARE COST CONTAINMENT

The National Governors' Conference finds that recent inflation in the cost of medical care is an unreasonable and unnecessary burden on society. The cost of medical care is causing serious dislocations in the national and State economies. The current level of expenditure on medical care will require us, as a Nation, to forego the production and purchase of other needed goods and services in order to finance this sector of the economy.

Based upon the experience of several States, the National Governors' Conference is convinced that the problem of hospital costs is complex and not amenable to simple solution. For this reason, the conference urges the enactment of a strong national statute that establishes a joint Federal and State government cost containment program. The National Governors' Conference recommends the development of a cooperative program that includes a common reporting system, and is based upon the decisions reflected in each State's health plan and medical facilities plan. Without common reporting, we will be unable to judge the success of a cost containment program; without a basis in State plans, decisions made through a cost containment program can create serious discontinuities in the development of a State medical care system.

To succeed, a medical care cost containment program must have at least the following characteristics:

1. In recognition of the differing needs of States for the development of health services, budgets for medical care expenditures within each State should be individually negotiated, within a cost-containment program.

(a) Such a program must include a national capital expenditure target which will be achieved through State government capital expenditure review programs.

(b) Cost containment must include an enforceable limit on annual increases in the revenues available to covered providers.

(c) A cost containment program must provide for the reallocation, through the State health planning system, of any medical care resources whose present utilization is no longer appropriate.

(d) The program should include incentives for effective State government administration and should allow States which do not have existing cost containment programs to develop such programs as long as State standards are at least as restrictive as the Federal requirements.

2. As a regulatory program, it must vest authority and responsibility in appropriate State government agencies and officials.

The National Governors' Conference urges the enactment of a national hospital cost containment program as a first step in the reform of the medical care system. The conference offers the assistance of its staff to the administration and the congress in the design of such a program and urges each governor to make such assistance available from his or her own staff.

Mr. SIMONS. Incentives should be provided the States to encourage the establishment of such commissions. S. 1391 recognizes this need by allowing State operating programs to approve revenue increases up to 110 percent of the Federal limit, and provides funding to the States for the establishment of these commissions.

We believe that similar incentives should be incorporated into S. 1470. In any event, S. 1470 must clarify how the performance of State commissions will be measured against Federal standards.

We urge that the criteria for comparison be as simple as possible and avoid the need for a dual system of accounting and recordkeeping on the part of hospitals or States. There is not yet sufficient experience available under several State programs to confirm their effectiveness.

All five States—New York, New Jersey, Connecticut, Maryland, and Rhode Island—which have had operational cost control programs for the last several years have had increases in total patient revenue below the national average from 1974 to 1976.

Moreover, the two States with fully operational prospective budget agencies should show outstanding results for fiscal 1977.

In Connecticut, total patient revenue increased by only 11.7 percent and in Maryland by only 10 percent compared to a national increase currently estimated by AHA at over 17 percent. Even more encouraging is that for 1978, Connecticut hospitals requested increases of 9.9 percent and the hospitals have now agreed on a figure of 8.2 percent for fiscal 1978.

We are convinced that the existence of the commission has helped insurers and help the professionals take a fresh look at health care in Connecticut, and savings have been achieved without sacrificing any quality.

Recognizing that not all States will establish commissions, an effective Federal substitute is imperative. I would like to take a few minutes to comment on the specific program that you propose.

I recognize your proposals are still not in final form. I will therefore take the approach of certain suggestions, rather than specifically endorsing a bill.

When we testified initially on 1470, we stated, in order to be equitable and effective, the bill should be expanded to cover all third-party payors and all sources of hospital revenue. We question the effectiveness of a system that applies only to inpatient care and then only to routine operating costs which comprise approximately a third of the total cost of such care.

We noted that such a system would allow hospitals to adjust the allocation of expenses to outpatient costs and to those inpatient costs which could be defined as ancillary services.

Proposed revisions of S. 1470 answer most of those concerns. The revised alternative approach would monitor as much as 80 to 85 percent of the total cost of patient care in acute care hospitals. It covers both revenues derived from routine services and revenues from ancillary services, with a "cap" on each category.

Thus, the revision eliminates most of the threat of a hospital being able to adjust revenue through allocation of expense to ancillary services.

However, the proposal still does not include the controls on hospital revenues from outpatient services, and we believe it should. In fact, we are convinced that a system which controls total revenues from all sources is really the only adequate control.

We would also like to make several points about the proposed controls in S. 1470.

With respect to the ancillary services, the formula would allow a hospital total revenue based on average costs per admission times the prior year's admissions. A hospital that reduced admissions by 10 percent could increase charges to other patients substantially and remain within its revenue limits.

Additionally, for increases in admissions up to 102 percent a direct increase in ancillary revenues is allowed. We believe using a narrower band of 97 to 103 percent of prior year's admissions in which the revenue limit would not be adjusted would be a more effective control.

With respect to per diem maximum on routine services, we believe that stronger incentives must be incorporated to control length of stay.

The formula seems to encourage increasing the length of stay by simply allowing the hospital to determine its total revenue limit by multiplying average per diem by actual number of days of confinement.

Moreover, extending confinements would not substantially increase the use of ancillary services and therefore would not cause a hospital to exceed the ancillary services limit. Requiring hospitals to meet length-of-stay criteria such as those required by the PSRO's in order to be eligible for bonus payments would provide the necessary controls.

S. 1391 places the same revenue limits on all regulated hospitals, regardless of the hospital's size, location and other characteristics. We believe that the imposition of this same revenue limit on all institutions will be unfair to cost-effective hospitals and overly generous to others. The revisions of S. 1470 answer this problem by treating dissimilar hospitals in different ways. The revisions allow for the grouping of hospitals, thus allowing similar hospitals to be compared to each other, rather than to all hospitals in general.

The requirement that a hospital be within 20 percent of the group average to qualify for bonus payments appears to be overly generous. A 10-percent maximum coverage would provide considerably more incentive.

Finally, we question whether the automatic 3-percent allowable increase in routine revenues and 1-percent increase in ancillary, taking into account increases in utilization and intensity, are really required in all instances.

In a more general vein, it appears that the revisions to S. 1470 handle the question of wages in a constructive manner. On the other hand, S. 1391 provides a mandatory passthrough of wages of nonsupervisory personnel for the Federal program and for any State program created under section 119 of that bill.

Although the passthrough is optional for those States with existing programs that qualify under section 117 of the bill, we believe that such a passthrough of wage increases for nonsupervisory personnel will provide little incentive for the type management of the institution in dealing with excessive employee wage demands.

We believe that this is a more reasonable provision than the current version of S. 1391.

S. 1470 provides for the exclusion of only a very limited number of hospitals from the control process. While we believe that the process should apply to every hospital, we find exclusions in S. 1470 more acceptable than in S. 1391.

As we testified previously, we believe strong incentives are required to cause hospitals to want to operate more efficiently.

Senator TALMADGE. I regret to have to call time on you, but we do have quite a number of witnesses this morning. We must strictly adhere to the time limit.

We do appreciate your very constructive testimony and your offer to work further with the staff in helping us to perfect our bill. We hope that you will continue to do so.

You point out that some of the States are effective in controlling costs. Where States can control costs, and do so at least as well as or better than the Federal Government, we will be glad to yield to the States.

Any questions, Senator Dole?

Senator DOLE. I have no questions.

Senator TALMADGE. Thank you very much for your constructive testimony.

Our next witness is Dr. Arvin B. Weinstein, President of the National Kidney Foundation.

Dr. Weinstein, you may insert your full statement into the record and summarize it, please.

**STATEMENT OF DR. ARVIN B. WEINSTEIN, PRESIDENT,
NATIONAL KIDNEY FOUNDATION**

Dr. WEINSTEIN. Thank you, Mr. Chairman.

I am Dr. Arvin Weinstein. I am a professor of medicine at the University of Wisconsin Medical School, director of the artificial kidney program at that hospital, and I am currently the president of the National Kidney Foundation.

I come before you today to testify on behalf of the National Kidney Foundation.

Mr. Chairman, I am familiar with the previous hearings on the medicare end stage renal disease program that were held by the Subcommittee on Oversight of the Committee on Ways and Means in the House of Representatives in the 94th Congress and testified in July 1975 on behalf of the National Kidney Foundation.

It was also my privilege to testify on behalf of the Foundation on the earlier form of the bill, H.R. 3112, before the Ways and Means Committee, Subcommittee on Health, House of Representatives in April 1977. I and my colleague from the National Kidney Foundation have had the opportunity to make some suggestions and give some advice to the staff of the subcommittee which led to, we think, to some very important improvements in the bill as it appears in its current form, H.R. 8423.

I want to commend the drafters of the bill for producing a piece of legislation that we think will, in fact, make very important improvements in the administration of this singularly important program for patients with end-stage kidney disease.

I would like to comment, Mr. Chairman, on the fact that the benefits to end-stage renal disease patients under the medicare program are very difficult to describe adequately. This program has had, in our view, incalculably beneficial effects on the access to care for the end-stage renal disease population throughout the Nation.

We have been concerned, as have others, with the question of the cost of the program. Our position, however, and the thing we want to point out, Mr. Chairman, with considerable conviction, is that there has in fact been real cost containment in terms of dialysis cost per patient treated per year since the program became effective.

The rising costs are entirely attributable, in our view, to the increasing number of beneficiaries of the program since it became effective.

This containment of costs per year of treatment has occurred during an interval when there has been continuing inflation of all other health care costs.

Mr. Chairman, we endorse and support H.R. 8423 because it is, in fact, designed to correct a number of existing inequities to improve the care of end-stage renal disease patients, remove disincentives—in

fact, provide incentives, important incentives, to the modalities of care that enhance the potential for rehabilitation. We also think that the bill will substantially improve the working relationship between the providers of health care services for this patient population and the administrators of the program.

This will be achieved because there is a strengthening and a definition in statute of the role and responsibility of the network coordinating councils and their medical review boards. We think that the bill provides an opportunity for greater cost effectiveness in a program that is inevitably expensive, that is, the care of patients with end-stage renal disease.

We make this judgment based on the fact that there are important incentives for self-care dialysis, more specifically for home dialysis, incentives that should remove many of the barriers to getting patients into home dialysis.

We think that the incentives for transplantation are entirely logical and we support the expansion of benefits by the lengthening of coverage from 12 months to 36 months after transplantation; and, very importantly, immediate entitlement when the transplanted kidney fails and the patient requires return to dialysis.

We speak with great conviction about the importance of the networks for peer review. We are persuaded that the bill provides an opportunity for the network coordinating council members—that is, the people providing care in the networks—to develop criteria and standards for judging the quality and appropriateness of patient care within the network areas.

The networks would be empowered to define their goals and to develop strategies for getting patients into modalities of treatment that offer the best prospect for rehabilitation. The networks, of course, are obligated to report to the Secretary on an annual basis on the progress that they have made in achieving these goals and their plans for remedying deficiencies in the system.

We place great stress on the importance of people within the 32 network areas, addressing their concerns and problems within their network areas.

It is important in our view, Mr. Chairman, that the network experience and performance will be judged against prospective national objectives with respect to the appropriate percentage of patients who come into self-care dialysis settings and are preparing, or have, in fact, undertaken transplantation.

We are much more comfortable with the articulation of national goals rather than what was in an earlier version of a bill; that is, fixed quotas for self-dialysis.

Regarding the various incentive reimbursement provisions, our specific concern here is that the incentives for greater cost effectiveness, that is, attempts to achieve cost containment, remain consistent with maintaining quality care. The National Kidney Foundation clearly supports the intent of these provisions so long as the methods or procedures employed do not threaten to impair the overall quality of services provided.

In summary, then, we endorse virtually all of the important provisions of the bill. We believe that the provisions which authorize the

Secretary to conduct very specific pilot projects, studies to improve the program, and the requirement that the Secretary report to the Congress annually on a wide variety of assessments made of the success of the program, are important and crucial provisions of the bill and we believe on this basis that the Congress will be able to make some careful and comprehensive evaluations of the success of the program.

Mr. Chairman, on behalf of the National Kidney Foundation, I want to express my gratitude for the opportunity to provide you with our view of this bill.

Senator TALMADGE. Thank you very much, Dr. Weinstein, for a very constructive statement. As you know, most of this bill is the handiwork of Chairman Long of our committee who introduced a similar bill in the last Congress.

In your opinion, what are the greater shortcomings in the present medicare programs for people who have suffered kidney failure?

Dr. WEINSTEIN. Mr. Chairman, I do not think that the problems within the program are entirely ascribable to statutes or rules and regulations as they currently exist. There are a number of problems and difficulties with the administration of the program that will be remedied by passage of the current version of the bill, i.e. H.R. 8423.

I think that what we have to look to, Mr. Chairman, is that this is an evolving system. The health care system was providing care for end-stage renal disease patients prior to enactment of this medicare legislation, but the availability and access to services was exceedingly uneven and varied markedly from one State to another, and from one region to another.

Superimposition on the entire kidney health care system of this unique catastrophic coverage produced predictable problems within the system because there were preexisting mechanisms, inadequate as they were, for dealing with these patients and their problems.

There is, in our view, a need in each area to allow the people in the networks to address the deficiencies and remedy the inadequacies of the program, and we believe that under the current bill, H.R. 8423, under these amendments, we will provide the very best opportunity for these problems to be addressed at a local level.

There is one crucial aspect of this, Mr. Chairman, and that is that it will take a very substantial effort in the networks to persuade patients that for many of them, self-care is an appropriate way to receive dialysis. We have removed disincentives in the bill. It will take some time before it is generally appreciated that for many, but not all patients who require long-term dialysis, that self-dialysis is, in fact, a preferable form of treatment.

We are depending upon education of both patient population and the people who provide care to move toward these national goals.

Senator TALMADGE. Does the present medicare payment system result in windfalls for some doctors in dialysis centers?

Dr. WEINSTEIN. We think that whatever windfalls occur are only identifiable, in our view, in a relatively small fraction of all units providing such services. It is our judgment that, on the whole, that there has been very little abuse of the system.

Senator TALMADGE. Senator Dole?

Senator DOLE. Thank you very much, Dr. Weinstein. I have a special interest in this, having only one kidney. I do not know whether I qualify for any program yet. I do not particularly want to.

Is there any particular problem with home dialysis? There have been all sorts of estimates of how much it would reduce the cost. I understand that different studies indicate rather wide ranges of cost.

What are the advantages and what are the disadvantages of home dialysis?

Is the mortality rate greater at home, or not?

Dr. WEINSTEIN. No, Senator. In fact, the available information in the medical literature, would indicate that patients who have carried on home dialysis have done at least as well as patients who are dialyzed in centers, whether in hospitals or out of hospital centers.

In fact, some groups have reported a better survival rate for patients doing home dialysis.

It should be appreciated, of course, that there is a certain amount of selection for patients who are going home in the sense that those patients with a more serious multiple organ system diseases, for instance, strokes and heart disease, are less likely to get into the home dialysis setting, so that the hospital and other center units will have their mortality statistics affected by the fact that they are dealing, on the whole, with a somewhat sicker patient population.

In our view, self-dialysis in the home has the advantage of fostering rehabilitation, of helping the patient and other family members adjust to the problem of chronic disease requiring dialysis. It offers greater flexibility in terms of the schedule of dialysis. As I am sure you know, for most patients, the dialysis schedule is two or three times a week. They can alter their schedule slightly. They can fit the schedule into their work requirements and other responsibilities and they will, as a group, be far more adequately motivated to look after their own health care needs.

I should, of course, comment, Senator Dole, that this modality of treatment is not suitable for all patients. That, in fact, as the program has expanded and we have taken in older patients with multiple organ system disease, heart trouble, past strokes, taking in more patients with diabetes who have multiple problems with vision, with heart, with circulation, many of those subjects are, in fact, not suitable for self-dialysis.

I hope I have been responsive to your question.

Senator DOLE. One big advantage, as I understand it, is the savings that it could bring about. Is that correct?

Dr. WEINSTEIN. There is no question but that home dialysis is a less costly way to treat patients. The figures that have appeared in the literature and which Dr. Blagg and others can testify to, indicate that on an annual basis, home dialysis will cost anywhere between 50 and possibly 60 percent of conventional in-center treatment.

The exact costs are hard to assess because some home dialysis programs provide more services to the patient in the home than do others; so that if you provide backup support with social workers, nurses, technicians and other services, then for those particular facilities, the cost would be somewhat higher than those who provide less.

These supportive services have to be individualized. Some patients become so self-sufficient that they virtually require no home services

once they are trained and are established in the home. Others require considerable support from the center.

Senator DOLE. As you know, when the program was first enacted, I think the estimated cost at the end of the fourth year was \$240 million and it has gone to \$900 million, nearly \$1 billion, so there is no question of the need for cost containment.

But I guess what we want to make certain is that we just do not face it from an economic standpoint, that we look at the welfare of the patient and what that may cost and whether or not there is a better way, a more economical way, that does not compromise the interest of the patient.

Dr. WEINSTEIN. Senator Dole, we appreciate your concern. I would like to reiterate the fact that the increasing annual cost of the program is related to the larger number of beneficiaries.

Senator DOLE. About 36,000?

Dr. WEINSTEIN. Approximately 36,000 this year. During the first full year of the program, there were something like 15,800 patients, that is, during the year 1974. We have gone from about 15,800 to something like 35,000 to 36,000 beneficiaries, currently.

Senator DOLE. That is only double; the cost has almost quadrupled.

Dr. WEINSTEIN. We have looked carefully at the annual cost and they have a very professional relationship to the number of patients in the program.

Senator DOLE. What is that breakdown per patient, just in raw numbers?

Dr. WEINSTEIN. There is another part of this equation. Also included in the program are the costs related to transplantation, so that that figure for total annual costs would be substantially affected by how many transplantations were carried out during that year.

Senator DOLE. There are not too many of those, are there?

Dr. WEINSTEIN. There has not been a significant rise in the annual rate of transplantation. There has only been a moderate rise. Each patient who gets transplanted also, of course, has continuing costs which are only covered during the first year.

Senator DOLE. We understand that. That is going to be changed?

Dr. WEINSTEIN. That is going to be changed to 36 months. That additional 2 years of coverage is not going to cost per annum per patient the same amount that it does during the first year because the frequency of outpatient visits and laboratory tests are substantially diminished.

Senator DOLE. Thank you.

Senator TALMADGE. We just received a report from the Social Security Administration regarding per patient per treatment costs. Without objection, I will place that in the record.

[The material referred to follows:]

Based on Medicare operating experience for the past several years it is estimated that the cost of a maintenance dialysis treatment provided in a facility setting averages \$150 per treatment. Since these treatments are provided on an outpatient basis the program reimburses 80 percent of this amount.

Allowable charges under the program for maintenance dialysis treatments provided in the patients home average \$75 per treatment. Of course some categories of medical supplies and certain support services are covered in the facility but are not covered in the home, therefore, the \$75 per treatment average is somewhat understated. However, these noncovered items are valued at approxi-

mately \$10 per treatment, thus the margin of difference in the costs between facility dialysis and home dialysis is still substantial.

The primary reasons for significantly higher costs for a dialysis in a facility setting relate to labor costs e.g. nurses, technicians, etc. and facility overhead costs. Labor costs approximate \$42 per treatment and overhead costs approximately \$35 per treatment of the total \$150 treatment cost. Of course neither of these costs are present in the home setting. It should be recognized that the cost of equipment in the facility setting is less than in the home setting due to more efficient utilization of equipment, i.e., a dialysis machine in the facility is used by more than one patient. As a result there is a modest offset in the margin of cost difference between the two settings that result from labor and overhead factors.

The program currently is reimbursing many nonhospital facilities without the benefit of cost information but has limited payment to these facilities to the equivalent of \$150 per treatment. Hospitals (and some nonhospital units that have furnished costs) are reimbursed on the basis of costs. The \$150 per treatment estimates and average costs for labor and overhead are based on the cost information supplied by these facilities.

Senator TALMADGE. Thank you very much, Dr. Weinstein.
[The prepared statement of Dr. Weinstein follows:]

STATEMENT OF ARVIN B. WEINSTEIN, M.D., PRESIDENT, NATIONAL KIDNEY
FOUNDATION

SUMMARY

The leadership of the National Kidney Foundation favors the enactment of this amendment because it will correct a number of inequities and improve care for beneficiaries, enhance the cost effectiveness of the program and foster an improved working relationship between the providers of health care services for end stage renal disease patients and the administrators of the program.

The National Kidney Foundation strongly endorses the provisions designed to achieve the following major improvements in the program:

1. Liberalization of benefits and removal of existing disincentives for patients who are suitable candidates for self care and specifically home dialysis.
2. Extension and broadening of coverage for potential and current kidney transplant recipients.
3. Strengthening and defining the role of the Networks and their Medical Review Boards so that the major responsibility for developing and articulating the goals of the Network, monitoring and evaluation of strengths and deficiencies in the end stage renal disease system in the Network area and assessment of the appropriateness of patient care practices will in fact be assigned to the Network organizations.
4. Clarification of the role, responsibility and authority of the Secretary in the following areas: (a) relationships with the Network Coordinating Councils; and (b) the conduct of specific pilot projects and studies to test innovative approaches to greater cost effectiveness, better patient rehabilitation, a larger fraction of patients performing home dialysis and improvement of the cadaveric organ donor system.

We also strongly endorse the provision which requires the Secretary to make annual reports to the Congress on all the aspects of this program so that the Congress will be able to carry out annual review and assessment of this unique and landmark commitment to a highly select group of our fellow citizens, the patients with end stage renal disease.

STATEMENT

Mr. Chairman and members of the committee, I am grateful for the opportunity to comment on H.R. 8423, a bill designed to make improvements in the End Stage Renal Disease Program presently authorized under Section 226 I of the Social Security Act. I am Dr. Arvin B. Weinstein, Professor of Medicine, Director of the Artificial Kidney Unit at the University of Wisconsin Hospital and President of the National Kidney Foundation. I am familiar with hearings on the Medicare End Stage Renal Disease Program before the Subcommittee on Oversight, Committee on Ways and Means of the House of Representatives

in the 94th Congress and testified on July 30, 1975 on behalf of the National Kidney Foundation.

It was also my privilege to testify on behalf of the Foundation on the earlier form of the bill (H.R. 3112) before the Ways and Means Committee, Subcommittee on Health, House of Representatives on April 25, 1977, as well to provide additional suggestions and advice to the staff of the Subcommittee following the hearings. As the spokesman for the National Kidney Foundation, I want to commend the drafters of this legislation for their serious commitment to the goal of improving the operation of this landmark program. We were very pleased to learn that H.R. 8423 was passed by the House of Representatives on September 12, 1977. The National Kidney Foundation strongly endorses this important legislation and urges early and favorable action on this bill by the Senate of the United States.

BACKGROUND

The availability of coverage for end stage renal disease patients under Medicare has had an incalculably beneficial effect on access to end stage renal disease services throughout the nation. There has been a considerable concern expressed both in the Oversight Committee hearings presided over by Mr. Vanik as well as in other forums about the very high cost of the program. I believe, however, that a careful review of the data provided by the Social Security Administration will support the contention that there has been a real cost containment in terms of dialysis cost per patient per year, despite the continuing inflation of other health services costs. The primary reason for the rising cost of the entire program is in fact attributable to the marked increase in the number of patients covered in the program each year since July 1973. During the first full calendar year of coverage under the Medicare program, that is 1974, there were about 15,800 patients receiving maintenance dialysis treatment. This number had increased slightly more than twofold by 1977, that is the estimated number of patients in dialysis for this year will be about 32,700.

It is projected by the Actuarial Office of the Social Security Administration that there will be a continuing rise in the dialysis patient population so that by 1980 the total number of patients will be about 45,000. A commensurate rise in the total cost of services to this population has occurred with the Medicare Program bearing the largest part of this rising cost. The estimated cost of the Medicare End Stage Renal Disease Program for 1977 is 757 million dollars. The prospect is that by 1981 this figure will exceed 1.6 billion dollars. These projections are obviously a matter of serious concern to the Congress as well as to the private sector. Nonetheless, the National Kidney Foundation is strongly committed to the position that there is no defensible alternative to maintaining a federally funded program which has made the benefits of dialysis and transplantation available to tens of thousands of our fellow citizens.

Although some reduction in the average dialysis cost per patient per year can be achieved and would result in a reduction of the annual rate of rise of Medicare program costs, it would be unrealistic to look to this strategy as a definitive answer to the problem of rising costs. Likewise it should be realized that even a substantial increase in the annual number of kidney transplantations performed would only have a very modest effect on the total size of the dialysis population.

We are caught in a great dilemma: overall program costs will inevitably continue to rise yet the public conscience and our sense of social responsibility precludes our denying the benefits of the best available treatment to these patients. Ultimately, there will be an alternative to these expensive means of treating end stage renal disease. It will come out of a basic understanding of the causes of end stage kidney disease. Only when we have the knowledge to prevent and cure renal disease can the burden be lifted. We believe, therefore, that it is prudent public policy to invest a larger fraction of the total health care expenditure in basic research and have testified in support of this position on previous occasions.

ENDORSEMENT OF H.R. 8423

We endorse and support H.R. 8423 because it is designed to correct a number of existing inequities, improve the care of end stage renal disease patients, remove disincentives and in fact provide important incentives to the modalities

of care which enhance the potential for rehabilitation. In addition it will foster an improved working relationship between providers of health care services for this patient population and the administrators of the program by strengthening and defining in statute the role and responsibility of the Network Coordinating Councils and their Medical Review Boards. If properly administered it will also improve the cost effectiveness of an inevitably expensive program, i.e. life support by dialysis and/or transplantation for a relatively limited group of our fellow citizens, patients with end stage renal disease. These judgments are based on the following important provisions in H.R. 8423:

INCENTIVES FOR SELF-DIALYSIS

These include waiver of the 3 month waiting period for patients who enter a self-care training program, coverage of disposable supplies and supportive services by facility personnel for home dialysis patients and authorization of full reimbursement to facilities for purchase of and maintenance of dialysis and supportive equipment for home patients.

INCENTIVES FOR TRANSPLANTATION

Liberalization of coverage including entitlement beginning with the month in which the patient is hospitalized in preparation for transplantation if it is accomplished within the month or the two succeeding months, extension of coverage to 36 months from 12 months, immediate resumption of Medicare coverage whenever a transplant fails and clarification of coverage of expenses incurred by living related donors including post operative recovery.

RESPONSIBILITY AND AUTHORITY OF NETWORKS FOR PEER REVIEW AND PROGRAM GOALS

The bill clearly assigns the major responsibility to the Network Coordination Councils and their Medical Review Boards for developing criteria and standards for judging quality and appropriateness of patient care within the Network area as well as defining goals and strategies for identifying and placing patients in treatment programs most likely to achieve patient rehabilitation. The Networks are obligated to report to the Secretary on an annual basis the progress made in achieving these goals and the plans for remedying deficiencies in the system.

It is important in our view that Network performance will be judged against prospective national objectives with respect to the appropriate proportion of patients in self care dialysis settings and preparing for or undertaking transplantation.

INCENTIVE REIMBURSEMENT METHODS FOR SERVICES PROVIDED BY FACILITIES TO PATIENTS DIALYZING IN FACILITIES OR AT HOME UNDER FACILITY SUPERVISION

The goal of these provisions is to provide incentive for greater cost effectiveness and to achieve cost containment for dialysis services "consistent with quality care". The National Kidney Foundation supports the intent of these provisions so long as the methods and procedures employed do not threaten to impair the overall quality of services provided to end stage renal disease patients.

ANNUAL REPORT OF THE SECRETARY TO THE CONGRESS

We endorse the provisions which authorize the Secretary to conduct specific pilot projects and studies to enhance the effectiveness of the program. We also support and approve the requirement that the Secretary will report to the Congress on an annual basis the outcome of these studies as well as a detailed and specific analysis of all aspects of the program operation. The listing of information categories encompassed in the requested report is exceedingly specific and all inclusive and would provide the Congress with a truly comprehensive picture of the End Stage Renal Disease Program. It would indeed provide a basis for future planning and policy decisions at a national level.

Mr. Chairman and members of the Committee, I want to express the gratitude of the leadership of the National Kidney Foundation for providing us with the opportunity to testify on this important bill. It is our judgement that it will make many very significant improvements in the end stage renal disease program and we urge the Senate to take early and favorable action.

Senator TALMADGE. The next witness is Dr. Christopher R. Blagg, president, Renal Physicians Association.

**STATEMENT OF DR. CHRISTOPHER R. BLAGG, PRESIDENT,
RENAL PHYSICIANS ASSOCIATION**

Dr. BLAGG. Mr. Chairman, I am Christopher R. Blagg, M.D., director of the Northwest Kidney Center, Seattle, Wash., and president of the Renal Physicians Association. I am grateful for this opportunity to appear before the committee to present testimony on behalf of the Renal Physicians Association regarding the proposed amendments to the medicare end-stage renal disease program contained in H.R. 8423.

Our association endorses this bill wholeheartedly because of its encouragement of the greater use of self-care dialysis, and in particular home dialysis, and because of its encouragement of transportation. We would like to commend the authors of this legislation for their understanding of the present problems in implementing the ESRD program and their imaginative response in preparation of this legislation.

The Renal Physicians Association has had opportunity over the last 4 years to provide comments regarding the end-stage renal disease program not only to the Department of Health, Education, and Welfare, but also to Congress at the hearings before the House Subcommittees on Oversight and on Health, and now this committee. We believe that this bill, as presently constituted, will have a significant impact on the various problems which exist with the ESRD program at the present time. We urge this legislation be passed speedily to permit implementation of these amendments as soon as possible. We do not propose to discuss the many problems and concerns with the ESRD program which have been described in detail during the course of hearings in the House. Rather, our association would like to offer some comments on the bill itself.

I would stress that these comments generally are not of such a nature as to require appreciable modification of the bill, but rather are matters that the committee may feel worthy of inclusion in their report as strong recommendations to the Secretary and to the Bureau of Health Insurance.

The Renal Physicians Association commends those provisions of the bill to encourage transplantation by elimination of previous disincentives, particularly those related to limitations and entitlement requirements. However, it is important that in implementation of the bill, the mechanism for reimbursement established by the Bureau of Health Insurance should continue to include a means to provide for coverage the costs of testing other family members not selected as the living related donor.

In addition, although the bill extends earlier coverage to the patient admitted to hospital for necessary surgery in anticipation of a kidney transplant, as presently written a candidate for a cadaveric kidney transplant admitted to hospital for a preceding nephrectomy during the first 2 or 3 months on dialysis might not be covered, as such patients may have to wait for more than 2 months before a suitable kidney becomes available. Under these circumstances, we recommend the wording of the bill be altered so as to permit coverage during the first

60 to 90 days for surgery "in preparation for or anticipation of kidney transplant surgery" without a time limitation.

The Renal Physicians Association strongly endorses the provisions of this bill designed to encourage the use of home dialysis, and in particular the introduction of a new method of reimbursement for home dialysis. However, we believe it appropriate the committee consult with the Bureau of Health Insurance regarding the appropriate target rate and consider whether a figure of say 75 percent would be more appropriate than 70 percent.

We welcome the introduction of statutory authority for medicare payment to physicians for dialysis patients by both the customary individual fee-for-service basis and also on the basis of a comprehensive fee for aggregate physician services provided over a period of time.

However, we would suggest that the committee make specific recommendations to the Secretary and to the Bureau of Health Insurance regarding physician reimbursement for home dialysis. As written, the bill removes disincentives or provides incentives to patients and facilities to encourage use of home dialysis, but does not address the problem of providing an incentive to physicians. Present medicare physician reimbursement is an appreciable disincentive to physicians who may wish to encourage patients dialyzing in a facility to undertake home dialysis. This is because the majority of nephrologists caring for patients dialyzing at facilities are reimbursed by the traditional fee-for-service method rather than by the comprehensive fee for such services.

Present instructions from the Bureau of Health Insurance insist that the physician select only one or the other method of payment for all patients, whether they are dialyzing at a facility or in the home. Consequently, a physician now caring for facility dialysis patients and who is reimbursed by fee-for-service would receive reimbursement only for office calls for any patients who might undertake home dialysis.

The Bureau of Health Insurance, recognizing the many supporting services required by home dialysis patients, does provide for appreciable physician reimbursement for such patients through the comprehensive fee method, although this is still significantly less than reimbursement by either the comprehensive fee or fee-for-service for care of the same patients dialyzing in a facility.

We recommend that the committee direct the Bureau of Health Insurance to permit physicians reimbursed by fee-for-service for their facility dialysis patients to elect reimbursement by the comprehensive method for those of their patients who are treated by home dialysis. This would still result in overall cost saving to the ESRD program and yet would reduce the financial loss to the physician when patients dialyzing in a facility elect to undertake home dialysis.

During the recent hearings on this bill, the question of the relative costs of home dialysis and of dialysis in a facility was raised several times. Testimony provided by a number of witnesses, including myself, clearly demonstrated that there is cost saving with home dialysis. Similarly, data is available from the Bureau of Health Insurance which shows that monthly charges for services to home dialysis patients are less than for those on facility dialysis.

However, we would suggest that it is inappropriate to become involved in prolonged argument as to exactly how much money may be saved by encouraging a given percentage of patients to undertake home dialysis. While in no way denying the importance of the total cost of the ESRD program, it should be pointed out that the majority of witnesses, including patients, testified to the many advantages of home dialysis for those patients able to perform this.

The Renal Physicians Association has previously described home dialysis "as an effective and potentially liberating form of therapy for end-stage renal disease wherever practicable." Encouragement of home dialysis not only results in cost saving, but will help make more widely available the best form of treatment for more patients.

The Renal Physicians Association welcomes those parts of the legislation designed to provide incentives to patients who participate in a self-care dialysis training program prior to the third month after starting dialysis. One of the important requirements for successful home and self-care dialysis is a good dialysis training program for patients.

We believe the committee should recommend that the Secretary define carefully the requirements for a self-care dialysis training program, and that consideration be given by the Secretary with regard to the advisability of recommending minimal utilization rates and other standards in order to encourage a high standard for self-care dialysis training programs.

The Renal Physicians Association supports the encouragement of self-care dialysis in a facility. However, we believe it most important that the committee recommend that the Secretary define extremely carefully what constitutes self-care dialysis in a facility if the intent is that this can be equated with home dialysis.

Undoubtedly, self-care dialysis in a facility can provide the patient with many of the advantages described for home dialysis, and we believe that self-care with significant involvement of the patient in his own treatment has great benefits for the patient with any significant long-term chronic illness. However, it is essential that self-care in a facility be carefully defined so as to provide a reasonable reimbursement rate to a facility undertaking this.

More important is the need for such a clear definition if self-care dialysis in a facility is to be included among the goals to be established by network councils. If regional goals with respect to the appropriate proportion of network patients dialyzing in self-care settings, both facility and home, and undergoing or preparing for transplantation are to be set by networks, it should not be possible to meet these goals by providing dialysis in a facility using only minimal patient participation rather than true self-dialysis. Thus, it is essential that the Secretary study this issue most carefully before promulgating guidelines for self-care dialysis.

The Renal Physicians Association commends the bill for providing statutory authority for networks and medical review boards to perform specific functions. Because of the role of both network councils and health systems agencies in planning, and because of present uncertainties regarding the relationship between these organizations, we suggest that the committee urge the Bureau of Health Planning and Resources to consider the inclusion of one representative from a net-

work council on each State health coordinating committee. This would enable the professional expertise of network councils to be involved directly in planning at the State level.

Our association endorses in general the studies recommended to the Secretary in the bill, although we have concern about the spelling out in such detail of projects, experiments and studies to be accomplished. We believe it may be more appropriate to define such studies in very general terms, permitting development of detail by the Secretary in consultation with the ESRD community. Similarly, we are concerned that the proposed legislation requires a large quantity of specific information be made available by the Secretary to the Congress, and we question whether, even with the new medical information system becoming operational, it will be possible to provide such detailed information in a timely fashion.

The ESRD program has brought access to dialysis and transplantation to almost all Americans suffering from treatable end-stage renal disease. However, the last 4 years have brought to light many problems with the program as originally legislated and implemented. The Renal Physicians Association believes that this bill, H.R. 8423, will have considerable impact in correcting the majority of these problems. We are anxious to see this implemented as soon as possible in order to encourage further use of home dialysis, self-care dialysis and transplantation.

We are also particularly pleased to see that network councils and medical review boards are given statutory authority, as this, together with recent funding for network council operations provides the opportunity for the ESRD community to demonstrate its ability to plan for, supervise, and improve upon the treatment of chronic renal failure in the United States.

We urge early passage of this bill without significant change in order for the ESRD program to have the opportunity to bring about these much-needed improvements.

Senator TALMADGE. Thank you very much, Dr. Blagg, for your constructive statement.

Our next witness will be Phyllis Messer, executive director of the National Association of Patients on Hemodialysis and Transplantation.

**STATEMENT OF PHYLLIS MESSER, EXECUTIVE DIRECTOR,
NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS AND
TRANSPLANTATION, ACCOMPANIED BY GILBERT WILLIX, PRES-
IDENT, ATLANTA CHAPTER**

Ms. MESSER. Mr. Chairman, members of the subcommittee, NAPHT is grateful for the opportunity to appear here today and express the view of the kidney patient.

NAPHT's membership includes approximately 8,000 renal patients in every State of the Union as well as Guam, Puerto Rico and the Virgin Islands. We receive input from individual members as well as the leadership of our 14 chapters.

Mr. Gil Willix, president of our Atlanta chapter, is with me today. I will keep my remarks to a minimum so that you will also have an opportunity to hear from Mr. Willix during our allotted time.

We agree with most of the proposed changes found in H.R. 8423. Our comments are detailed in a more complete presentation which I will submit for the record. We would like to use our time here today to speak about one area which we feel no other witness will discuss—the area of patient participation in the end-stage renal disease program.

The thrust of the changes found in H.R. 8243 are designed to encourage more patients to select transplantation and home or self-care dialysis, as a cost containment measure. We encourage this because it will not only eliminate economic disincentives in the present law, but also permit the patient to be more independent.

If Congress truly wishes though, to encourage more self-care dialysis—to change the physical setting where dialysis takes place, then you must change your attitude toward the patient/physician relationship. If this program is to be a model program, the successful forerunner of catastrophic care, then Congress must take the lead and insure innovative methods in its implementation.

HEW has been implementing this legislation for the last 4 years. The regulations they have written have only been from the viewpoint of the provider and the payor. The patient has never been given an active role in the program. The regulations have destroyed any hopes patients may have had about playing a meaningful role in the planning and overseeing of the program thus negating their opportunity to help in holding down costs.

The regulations established the formation of regional networks, to supervise the planning and delivery of care within each area. The coordinating council was originally designed to be the governing body of the network. Three consumers are required on each coordinating council. Because of their unwieldy size, however, all networks will now be governed by an executive committee of no more than 20 members.

No executive committee has more than one consumer member on its roster. None are mandated. The other 19 members of the committee are the physicians working in facilities within the network and other professionals directly responsible to those physicians. In short, the professionals who earn their livelihood within the network will be making all the decisions for the delivery of care for the network. We see this as a conflict of interest.

The number of consumers on these governing bodies will not increase unless it is legislated by Congress. The precedent has been established with other health care legislation. The Comprehensive Health Planning Act of 1966, and more recently the National Health Planning and Resource Development Act, Public Law 93-641, mandates governing bodies composed of a majority of consumers, as does the 1963 Mental Health Centers Act. Other legislation which has placed consumers onto governing bodies in the health field, deal with HMO's, and Neighborhood and Migrant Health Care Centers under the Public Health Services Act. Most recently Public Law 94-562 established advisory boards for arthritis, diabetes and digestive diseases, with one-third to one-fourth consumer membership.

Why cannot Congress do the same for the renal disease program? This may be one of the most important pieces of health care legislation in our generation. It is certainly the first one in which the taxpayer is so heavily committed to paying the bills for one particular type of health care.

Why is the consumer's voice important in this arena? Sit in on any HSA committee meeting anywhere in the United States and you will find it is usually the consumer, not the provider who is fighting for cost containment. No one is more concerned than the renal patient with the success of this medicare program. We implore you to give us a role in its implementation.

If this program is successful it will benefit all Americans waiting in the background for their opportunity to be assisted with the costs of catastrophic illness. If it fails, the consequences will be felt by more than kidney patients.

The National Institutes of Health recently funded a program to study dialysis facilities in several European countries. This is related to their interest in health consumer trends. They are concerned about the social and economic impact of medical care on the patient.

The questions our social scientists are trying to find answers to in Europe are not being considered seriously by officials here.

No one knows better than the patient the social and economic impact of illness on his or her life style, and yet the patient is being excluded from any meaningful role in the operation of the renal disease program, where many nonmedical decisions are made which effect his or her life.

A simple example of this is the hours available at most units offering dialysis. Since the introduction of medicare facilities have expanded and created additional shifts to meet the ever-increasing need. Many are now expanding their physical structure, adding more machines and reducing the number of shifts, down to the two required by the regulations. No consideration is given to the working patient. The two shifts are usually daytime by tradition—and patients are often told to stop working or change their facility.

Without more consumer membership on the governing bodies of each network, costs will continue to spiral and patient needs will not receive the proper forum. We feel after 4 years of working with HEW that a mandate for more consumer input will not come from them. It must come from the Congress.

The House version does not provide for this. This bill you are considering today does give legislative approval to the already established networks. We implore the Senate to add this to the bill. This is your opportunity to mandate consumer input into the program. If you want it to work, if you want to reduce costs, then you must give a voice to the group who has the biggest stake in the success of the program—the consumer.

Senator TALMADGE. Thank you for a fine statement. I agree with you that the patient should have more say-so in a program of this sort and nature.

Mr. Willix, how many members do you have in the Atlanta chapter?

Mr. WILLIX. Today, we have approximately 60 paying members. We have a list of correspondents of nearly 500 who are patients in the city of Atlanta.

Senator TALMADGE. In the Atlanta area alone we have some 600 patients who are now on dialysis treatment?

Mr. WILLIX. In the State of Georgia, in patients alone, we would have some 350 to 400.

Senator TALMADGE. 350 to 400.

Mr. WILLIX. We correspond and try to help the supporter of the dialysis patient as well as the patient himself. I have copies of my remarks. Would you like to have them?

Senator TALMADGE. Without objection, we will insert your remarks in full in the record.

Senator TALMADGE. Exactly what does the Atlanta chapter do?

Mr. WILLIX. Our main thrust is to work with the patient as he is told that he is going to be a user of the dialysis system. We think that it is very important to find the patient prior to the time that he goes on dialysis, to acquaint him with the new life that he is going to have.

We think that because we are patients, we know what it means to be a patient. We think that we can prepare him for the new life that is going to be for him, probably in the future.

Senator TALMADGE. In general, I would suspect that it would be helpful advice, sympathy, cooperation, and things of that nature?

Mr. WILLIX. Very true.

Senator TALMADGE. In other words, if you were an alcoholic, it would be similar to AA.

Mr. WILLIX. I would like to think of myself as that, yes.

Senator TALMADGE. Senator Dole?

Senator DOLE. I have no questions.

Senator TALMADGE. Thank you very much; we appreciate your contribution.

[The prepared statements of Ms. Messer and Mr. Willix and a letter from Mr. Willix, follow:]

STATEMENT OF THE NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS AND TRANSPLANTATION

In commenting on H.R. 8423, we will first summarize those changes which we have urged since the beginning of the renal disease program. We are happy to see them included:

1. For transplants (who have had the highest out-of-pocket expenses).
 - A. Extension of medicare coverage from 12 to 36 months.
 - B. Elimination of the waiting period when a kidney rejects, and the patient must return to dialysis.
 - C. Coverage of medical expenses for donor including actual period of recovery.
2. To eliminate the financial inequities of home vs. facility dialysis.
 - A. Coverage for all medically necessary supplies and equipment involved in home dialysis and inclusion of other supportive services.
 - B. A pilot project which would reimburse professionals and family members to assist with home dialysis.
 - C. Periodic monitoring of patient's home adaptation, including visits by qualified personnel.
3. To help eliminate financial disaster for those ineligible for Medicare, a study to determine effects on these individuals and consider mechanisms which would permit the purchase of coverage for these patients.

We also applaud the inclusion of pilot projects to: (1) purchase equipment for home patients; (2) study methods of increasing public participation in kidney donation; (3) study effects of diet on delaying dialysis.

QUESTIONABLE AREAS

There are three points in the proposed Amendment which we question:

1. The first deals with financial incentives for reuse of filters. If those who are able to reuse filters are rewarded, we have no objection. If however, an attempt is made to adopt this for all patients we would strongly object. In most cases the medical risks involved in reuse of dialyzers would far outweigh any financial gain. It could, in fact, contribute to greater medical costs for the entire program.

2. In order to encourage self-care dialysis the bill will eliminate the waiting period for medicare entitlement for those entering the self-care program. It is unfair to discriminate against those patients who through no fault of their own are physically or emotionally unable to participate in such a program. In fact, such a provision could easily encourage fraud, in order to save a family from financial disaster. A patient without private insurance could be enrolled in a self-care training program and after a three month period his or her doctor could decide the patient was not medically or emotionally suitable for the program. We feel that the waiting period should be eliminated for all patients once it has been medically determined they have chronic renal disease.

3. One provision of the amendment which received comment from all our representatives in the section calling for a percentage of patients to be enrolled in self-care training programs. A strong fear was expressed by our members that freedom of choice of therapy would in many cases, no longer be left to the patient. It is possible that 40 percent or 50 percent of the patients in the entire country today are suitable candidates for self-care dialysis programs. We question, however, if this is true within certain networks and if it will be true a few years from now. Networks with a disproportionate percentage of the population who are elderly or where housing and utilities are inadequate would have difficulty meeting arbitrary quotas.

NAPHT believes that each person should have the freedom to choose the mode of treatment best suited for him or her and the freedom to alter that therapy as need changes. Economic disincentives to transplantation and home dialysis have not always allowed patients this choice. This amendment will go a long way to correct this. Quotas however, may rob the patient of this freedom.

CONCLUSION

In conclusion NAPHT would like to state that the points included in the amendment designed to eliminate the economic disincentives to transplantation and home dialysis are good ones. They are needed to give all patients a true choice of therapy. This choice should not be waived, however, in order to achieve cost control. Costs can be controlled in the renal disease program as it is done in other programs—by giving the consumer an active role in the decision making policies of the program. This is the responsibility of Congress. You must take the lead if you are sincere in your wishes to offer quality care coupled with fiscal responsibility to those citizens of this country who have been afflicted with end stage renal disease.

STATEMENT OF THE NATIONAL ASSOCIATION OF PATIENTS ON HEMODIALYSIS AND TRANSPLANTATION, ATLANTA AREA CHAPTER

Mr. Chairman and members of the subcommittee. Thank you for this opportunity to speak on behalf of the 34,000 persons now being treated for renal disease.

I have been a patient for 2½ years, presently being dialyzed at a center, and fortunately have successfully adjusted to the regimen of life with the dialysis machine.

As president of the Atlanta Chapter of the National Association of Patients on Hemodialysis and Transplantation, I have had the opportunity to work closely with other patients and observe some of the problems—both psychological and financial—that dialysis patients face. And I know from experience how serious these problems can be.

I am concerned about the several sections of H.R. 8423 which specify minimum utilization rates for covered procedures and self-dialysis training programs. Although I am in full accord with increased emphasis on self dialysis as well as transplantation, I do question the practicality of a government mandate establishing a quota to be achieved.

Dialysis itself is a traumatic experience. It means a readjustment to a completely new way of life. Freedom of movement is restricted. The effect of the treatment is never predictable, and a patient, in most cases, must sacrifice to some degree the ability to earn a living. Some are never able to work again. All this would be compounded by requiring that every patient train for self-dialysis. For many, this would be completely impossible.

I have discussed transplantation with many fellow patients. This technique is still far from perfected, and to impose this upon a patient without adequate information to the patient and his supporter, or without the voluntary choice of

the patient, would be an infringement of their rights. To encourage them—particularly by offering financial advantages—is fine.

I can remember the day I was told I had end stage renal disease and must prepare myself for some other supporting method: a transplant, an artificial kidney, or a short life. I elected to use an artificial kidney.

The nephrologist is the only person qualified to advise the proper type of treatment. He understands the patient's physical and emotional stability. The patient needs qualified counseling to overcome his fears, and needs help to maintain a positive mental attitude.

About the feasibility of self-dialysis: It is an advantage for the younger patient, since it helps to make it possible for him to continue work if he can dialyze at night. But for some, it can disrupt family life and create intolerable situations. This can only be determined by the patient and his family.

We're all aware that there is presently little incentive to consider self-dialysis. The proposed legislation would do much to encourage it by providing the services of trained home dialysis aides. This could be the answer for those who could not handle it alone.

In reading the proposed changes in legislation, I feel that it is heavily weighed in favor of the government and the provider. The patients rights and requirements, I believe, should be up front in your planning.

As an example: the size of each Coordinating Council is large enough to require the appointment of an executive committee to oversee the implementation of the regulations. We urge that consumer input should be increased from one to a minimum of 25 percent. Congress has provided for larger consumer membership—from $\frac{1}{3}$ to $\frac{1}{4}$ —on advisory boards for such other concerns as arthritis and diabetes. We consider it the right of the consumer's voice to be heard on a Board responsible for implementing the directives you proposed. I believe we dialysis patients should continue to have the freedom to select the type of treatment best suited to us individually. We deserve the right to change the therapy as our needs change.

Dr. Michtel Goran, director of the Social Security Administration's Bureau of Quality Assurance, has said that the basic issue is: "Who makes the final determination as to choice of treatment. Currently and historically this has always been with the patient and his physician."

Speaking for the thousands of persons now enrolled in the dialysis program, we are sincerely grateful to those ahead of you who conceived the important legislation to help us, and to you who will be considering the suggestions that will determine our future.

Life on the dialysis machine is not a pleasant one, but your concern for us goes a long way to help make it bearable. And we believe that because of this concern, you are interested in hearing the patient's viewpoint as to his needs and capabilities in adjusting to rigid regulations before approving any legislation. We urge that you do not carve in stone any decisions about dialysis treatment that could add to your burdens and ours.

I. GILBERT WILLIX,
Roswell, Ga., October 21, 1977.

Senator HERMAN TALMADGE,
Chairman, Subcommittee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: Thank you for the opportunity to discuss with you on Friday, October 21, House bill HR 8432, from a consumer's viewpoint. Although my associate, Phyllis Messer, executive director of the National Association of Patients on Hemodialysis and Transplantation (NAPHT), had specifically held her remarks to five minutes to allow time for presentation of my prepared statement, you were not able to permit this. Therefore, even though I understand that the prepared statement will become a part of the testimony, I am compelled to add my further comments for the record.

The majority of the testimony the Subcommittee heard Friday morning was from the physicians' point of view. I had anticipated you would be seeking equal input from the consumer's standpoint.

You will see from my prepared statement that I am heartily in favor of home or self-care treatment. For this to be successful, it is important that provision be made for adequate pre-dialysis counseling. For example: a nephrologist often implants the fistula (the blood access device) several weeks or months prior to actual dialysis. This is the time when competent counseling must be made

available to better insure that the patient and/or prospective supporter will accept the home training program.

I recall that one of the physicians you heard categorically stated that home dialysis impairs the quality of care and that patients on home dialysis have a higher mortality rate. To this I take issue. From information I have been able to obtain during my nearly three years on the dialysis program, I have been led to believe that these home patients live longest; not the center patients.

As stated in my prepared remarks, I concur with these provisions of HR 8423: (1) Remove the three-month waiting period for dialysis; (2) Recommend payment of all home care costs; (3) Support services and, if necessary, to provide regular technical personnel when the patient cannot provide own supporter; (4) When home care is not feasible, make self care available in a center facility which would reduce the cost of center dialysis and at the same time allow the patient to select the hour of dialysis to agree with his work schedule and thereby remain a productive member of society.

The number of dialysis patients in the State of Georgia is growing considerably—in five of the nine centers in Atlanta, alone, there are approximately 300 patients. On behalf of the center patients and home patients, I urge that a more equitable balance be made in the representation of consumers vs professionals (physicians, nurses, administrators and owners) in the Regional Network Program. This program needs greater input from the consumers. It presently is weighted too heavily with professionals. It's like the fox guarding the chicken house. A minimum of three or four more consumers should be represented in the Regional Network Program.

I will appreciate your consideration of these additional comments on HR 8423 and ask that they be placed on record along with the prepared statement which I submitted.

Sincerely,

I. GILBERT WILLIX,

President, Atlanta Area Chapter, NAPHT.

Senator TALMADGE. The next witness is Dr. Edmund G. Lowrie, director of hemodialysis unit, Peter Bent Brigham Hospital, Boston, Mass., and assistant professor of medicine, Harvard Medical School.

Dr. Lowrie, you may insert your full statement in the record and summarize it as you will.

STATEMENT OF EDMUND G. LOWRIE, M.D., DIRECTOR OF HEMODIALYSIS UNIT, PETER BENT BRIGHAM HOSPITAL, BOSTON, MASS., AND ASSISTANT PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL

Dr. LOWRIE. Thank you, Senator.

I am Dr. Edmund Lowrie, assistant professor of medicine at Harvard Medical School and lecturer in chemical engineering at Massachusetts Institute of Technology and director of hemodialysis unit at the Peter Bent Brigham Hospital. My colleague, Dr. John Merrill, and I with others have carefully analyzed the costs and potential results of hemodialysis in the home and in the center. Our analysis indicates that the cost of self-care dialysis is not significantly less than limited care dialysis and that the indiscriminate use of home dialysis may lead to unacceptable patient mortality.

H.R. 8423 provides strong incentives for placing patients on a home or self-care dialysis and we submit that these forms of therapy should be prescribed based on their own medical merits rather than upon legislative incentive. Since the most relevant considerations in prescribing a therapeutic prescription is cost and effectiveness of the therapy, I will discuss each in turn. We will discuss costs first.

It may be worthwhile to examine why previous cost estimates for home dialysis have been erroneously low. Most such estimates have come from physicians, and physicians generally devote the greatest portions of their time to medical prescriptions rather than accurate cost accounting. Many costs were previously hidden in grants from the Federal Government or sequestered in other ill-defined and cost-reimbursement schemes within hospitals. They were therefore not properly accounted and included in reports by medical directors when furnishing data.

It is of interest to note that the Northwest Kidney Center in Seattle and the Peter Bent Brigham Hospital in Boston submitted estimates for the cost of home dialysis in mid-1975. Seattle testified at that time that the costs per treatment, including amortization of first year startup costs at about \$44 per treatment, exclusive of payments to a dialyzing partner. Boston, on the other hand, provided similar cost estimates indicating that they were about \$106 per treatment and \$137 if the dialyzing partner were included. The over twofold difference really taxes credibility.

Both institutions presented cost estimates again in April of this year. The Seattle cost estimate was revised upward by approximately 88 percent. The Brigham estimate was increased by about 12 percent over the 2 years to about \$119 per treatment, again excluding payments to a dialyzing partner.

A number of differences between the methods for cost accounting, however, still remain, and I have prepared a table which is in my prepared testimony, table 1, summarized for you here.

We note that plumbing and electricity at Brigham in Boston was a cost accounting for about \$500 and in Seattle about \$97. It is interesting to note that in 1975, the Seattle estimate was about \$250.

The biggest difference, however, is in our original estimates of supplies for dialysis. In Seattle, bloodlines and dialyzers are reused up to six times. Now, to make costs comparable, one must either cost-account for single use or multiple reuse. After all, if you can reuse dialyzers in Seattle, you can reuse them in Boston. If you should not reuse it in Boston, you should not reuse in Seattle. And certainly, if you can reuse in the home, you can reuse in the center—probably with greater safety, as a matter of fact.

We revised upward, therefore, their estimate as published in the hearings of the Oversight Committee from about \$30 to about \$54, slightly higher than that at the Brigham. They used dialyzers which are somewhat more expensive than our commonly used dialyzer.

Therefore, the estimates, excluding payments to a dialyzing partner, have now increased on a comparable basis in Seattle to approximately \$108 and approximately \$120 in Boston. If one includes estimates for the payments to dialyzing partners, with the estimated rates in both places, in Seattle the total cost for dialysis is now approximately \$139 for comparable service and \$142 in Boston. We have explained these figures in much more detail in a letter to Dr. John Merrill, which I have appended to my testimony.

The cost of \$140 per treatment is not substantially less than the medicare screen for limited care dialysis of approximately \$150 per treatment.

I will not provide a detailed discussion of in-center self-care dialysis, but to the best of my knowledge, the reimbursement rates for partial care in-center dialysis, full care center dialysis and full self-care center dialysis are the same. The screen is about \$150. Only about 1 percent of the country is on center-based self-care dialysis and recent reports from the ESRD medical information system indicates that only about 218 patients in the whole country are receiving this form of therapy.

I wonder, then, how Congress can advocate legislatively an untried medical form of therapy, the cost advantages of which are questionable, to say the least?

We are confident, that if Congress unreasonably promotes a form of therapy such as home dialysis, they will one day be awakened again by the realization that the costs have again spiralled beyond original estimates. Even worse, we fear that they may realize that a form of therapy which leads to greater mortality, or may lead to greater mortality, has been erroneously encouraged, and I would like to turn now to that topic.

Medical opinion is clearly divided on the relative benefit of home versus center dialysis. Some have pointed to the Northwest, indicating that 80 percent of patients are on home dialysis. A prominent physician from the Northwest has recently stated, "Our philosophy is that we do not discriminate; we select everybody for home dialysis, but if we do not solve the problems that arise, the patient may end up in the center."

On the airplane, I was reading an article by a young lady by the name of Marcia Clark who is a dialysis nurse in the Seattle area, published in the AANNT Journal, regarding payment—home dialysis with payment to a dialyzing partner. She states that, "The training time for such paid helpers is 2 to 3 weeks, similar to that for patients." She goes on to say that once the patient and once the helper has been trained that the center assumes "no further responsibility for his subsequent performance." She goes on again to say that the helper is not an employee and is not paid directly by the center for three reasons.

Now, the last of these three reasons is worth mentioning. "The Center also wishes to avoid responsibility for an employee, which the helper would be if he were paid directly by the Center, since close supervision of this type of arrangement is nearly impossible."

Now, within that same program, the 3-year survival rate for patients is 58 percent. The national average, according to the National Dialysis Registration, is closer to 68 percent, and most major centers within the country have survival rates which exceed 75 percent.

After careful analysis, the only obvious reason for this inferior patient survival that we can think of is the indiscriminate use of home dialysis therapy.

We must explore, however, possible reasons. Perhaps patients are selected more in one center than another. As Drs. Blagg and Weinstein have testified, acceptance criteria by centers is generally pretty liberal, and we believe that renal dialysis therapy is available to all Americans.

Most centers within the United States, however, select carefully those patients who will be placed on home hemodialysis in conjunction and consultation with the patients themselves. For example—I quote

the European experience—the European Dialysis and Transplant Association states, “Patients being started on home dialysis continue to be highly selected, firstly with a high male-female ratio, secondly with a high proportion of young patients.” We reported our survival rates, and found inferior patient survival in the home—at 2 years, 86 percent in the center versus 77 percent in the home.

The National Dialysis Registry finds similar rates of survival between the therapies. We submit that if better patients—that is, if those patients with fewer socioeconomic or medical problems, are present in the home, then one would logically expect that home dialysis should exhibit superior—not equal or inferior—survival rates.

Some nephrologists have pointed to the United Kingdom, stating that 68 or 65 percent of their patients can be placed in the home. This chart (Fig. 1 in written testimony) shows the percentage of home dialysis patients in various European countries plotted versus the new case rate per million population per year. That number is probably 40 to 60 new cases per million per year in the United States at this time, depending on geographical location.

Here is England with 65 percent home and a new case presentation rate of about 13 per million. This is Ireland, with maybe 42 or 43 percent home.

The average for all of Europe is about 18 percent home, and you can see that most European centers are accepting about 24 new cases per million population per year.

We would like to conclude, then, there, because my time has run out, Mr. Chairman, we would like to conclude then that highly selecting patients, such as was done in England—only 13 million—may lead to very high rates of home hemodialysis. On the other hand, we submit that placing patients unselectively in the home may, in fact, lead to inferior patient mortality.

Dr. John Merrill, my mentor, regrets that he cannot be here. He wishes the opportunity to testify actually before the committee and I wish a letter from him, to you, to be inserted in the record.

Senator TALMADGE. It will be placed in the record at this point. [The material to be furnished follows:]

HARVARD MEDICAL SCHOOL,
DEPARTMENT OF MEDICINE,
Boston, Mass., October 18, 1977.

Re hearings on H.R. 8423, scheduled October 21, 1977.

Senator HERMAN TALMADGE,
Chairman, Subcommittee on Health,
Senate Finance Committee, Washington, D.C.

DEAR SENATOR TALMADGE: Unfortunately, prior commitments preclude my attending the Hearings, and I have so informed your staff by Mailgram. You should not interpret my absence as a lack of interest. On the contrary, the legislation has the potential for affecting adversely medical care in a number of ways, and I would deeply appreciate the opportunity to discuss these matters personally.

Although I am unable to be in Washington on Friday, I have reviewed Doctor Lowrie's testimony with him. I concur with his observations and conclusions, although even much more could be said.

Very sincerely yours,

JOHN P. MERRILL, M.D.
Director, Renal Division.
Professor of Medicine, Harvard Medical School.

Senator TALMADGE. Thank you very much, Doctor, for a very helpful statement.

Any questions, Senator Dole?

Senator DOLE. How do you suggest, then, that we contain the costs of a program that has gone up almost to \$1 billion?

Dr. LOWRIE. Senator, I am not sure how those costs were arrived at. For example, we understand that SSA estimates that there are approximately 36,000 to 37,000 recipients in the country at this particular time. If we read the most recent report of ESRD information system, who actually sends questionnaires to each of the providers, the best that we can account for is approximately 30,000. Now, that is a variance of 20 percent.

I am not sure that we can actually say what the program for ESRD itself is, in fact, costing.

Senator DOLE. Well, I understand that the letter that you referred to breaks down the difference in cost between Boston and Seattle and indicates that there is not really any difference. You may not agree with that.

We have to find some way to protect the interests of the patients and also protect the interests of the taxpayer. I do not know what it breaks down to for each patient, but it must be \$16,000 on the average cost per year per patient.

Dr. LOWRIE. The division would be the number of patients by the total budget, Senator.

Senator DOLE. It would be higher than that.

The point is, we are talking about how we are to contain the costs. Have there been any objective studies made of the cost other than the Boston study and the Seattle study?

Dr. LOWRIE. I believe the CDC has conducted a study, and also performed an analysis of cost-benefits analysis, of various forms of dialysis therapy which I reviewed. Some portions of that I believe are unrealistic.

For example, they have not included a physician in their study team who is familiar with the service. There are some technical problems with the study, Senator, but their cost for home dialysis is, to the best of my recollection, on the order of \$15,000 to \$18,000 per year, exclusive of the home helper.

That would compare to center dialysis of approximately \$22,000 per year, more or less. The point being that the two forms of therapy are nearly equal to one another. One must either find a cheaper way to deliver the therapy in both center and home or reduce the total benefits which will accrue to Americans. I think that is the choice for the Congress.

Senator DOLE. Is there a reason that, in Seattle, 80 percent of the patients die on home dialysis—just the reverse of Boston?

Dr. LOWRIE. As the physicians from Seattle will testify, Senator, almost all patients who present to a dialysis facility are strongly encouraged and convinced that they should, in fact, go home.

As Dr. Blagg has stated they are unselective and 80 percent of the people go on home dialysis. If there is some problem, they may then revert to the center.

Miss Clark has said that this is a difficult-to-supervise situation and we contend that the difference here may have led to higher patient mortality.

Now, if one wishes to encourage a form of therapy, that leads to higher patient mortality without a cost benefit, I think that that makes no intuitive logic, Senator.

Senator DOLE. I was just checking the GAO study for 1972, average annual cost per center, \$30,000, versus \$14,900 home dialysis. I guess you would save more money with transplants. I do not know how many transplants are done.

Dr. LOWRIE. We participated in the GAO study. As a matter of fact, most information about some dialysis programs were furnished by physicians. We have also indicated most physicians are not competent in cost accounting.

We know, for example, that Seattle has increased by a substantial fraction their cost estimates between the time that the GAO report was published and the time that they submitted testimony in April. So our contention is that much of the information which was provided to the GAO may have been erroneously low for home dialysis, the costs being picked up by other funding centers within hospitals and institutions.

If one does not account for social service functions that are really essential to provide the patients, made available to the patients, because they are hidden in some hospital overhead charge, then the costs for home dialysis will be erroneously low.

With respect to centers, we do not wish to compare a specialty hospital center to a limited care outpatient facility. For example, if cost figures include provision of services to patients who are being dialyzed in medical intensive care units, the figures for the hospital will be erroneously high.

The home dialysis patient is really consuming services that are being paid out by the funds. We are trying to make the costs for these two forms of therapy honestly accountable.

I think at the very minimum, an objective survey of the relative costs of home versus center dialysis compiled by accountants, the 1977 figures, should be performed prior to enacting legislation such as this.

Senator DOLE. There is some indication in your statement that the mortality rate is higher in home dialysis. Is that correct?

Dr. LOWRIE. Our observation, Senator Dole, is that there is a 58-percent 3-year mortality in Seattle, according to Dr. Blagg's testimony. That is clearly inferior by national standards.

Senator DOLE. Fifty-eight?

Dr. LOWRIE. Yes; 58 by the National Dialysis Registry. It is more like a 75-percent survival in most centers around the country who are of similar caliber to those physicians in Seattle.

I must stress, Senator Dole, that I have the greatest regard for Dr. Scribner, Dr. Blagg, and all of my colleagues in Seattle, and the quality of medical care is really not an issue here. I think that it is a style or a mode of performing therapy. I think that we have seen paid home helpers go out into the home, according to the Seattle head nurse's article in a situation which is difficult to supervise, difficult to control.

If it is difficult to control technically, medicine is a technical science. Dialysis is a technical science. If it is difficult to control technically, one would logically expect inferior results.

Senator DOLE. You are suggesting that there be an updated study by the GAO using more precise figures based on 1977 costs, that that would be helpful?

Dr. LOWRIE. I think that it would be essential. I think that that should be combined with a detailed study of the patterns of health care using the ESRD medical information system which has been collecting data now for 2 years and has issued three reports to date.

Senator DOLE. I recognize that you and Dr. Blagg are experts in the field, but that you have different viewpoints. That is not unusual; we have those here occasionally.

How do we reconcile these viewpoints?

Dr. Blagg is about ready to jump out of his seat back there because he does not agree with your statements on mortality. Have you two discussed this?

Dr. LOWRIE. As a matter of fact, I just was unaware of their mortality figures until I read their testimony which is published in the proceedings before the Subcommittee on Health of Ways and Means, proceedings that took place last April.

Now, I read that about 2 weeks ago and Dr. Blagg and I saw each other transiently at the National Institutes of Health about a week ago. We did not discuss that matter, and I have not had an opportunity to do so today.

I have submitted, with testimony, a list of reference materials, and certainly all of my statements are open to objective scrutiny, as they were taken in their entirety from that reference material.

Senator DOLE. I do not have any further questions. Maybe you can understand the problem that the committee has, not only the committee, but that the American taxpayers have. I guess there are three alternatives: Transplants, home dialysis or any other dialysis. I guess there are four; you can die. We do not want that to happen.

Dr. LOWRIE. Senator, I believe that health care has evolved, and ESRD service to this country to a relatively high level in the past 10 years. It has done so unencumbered by a great many regulations.

In other words, each mode of therapy that you have outlined—home dialysis, center dialysis, self-care dialysis, and transplantation—has been selected for patients in most centers primarily upon the relative merits of each form of therapy as it applies to a particular patient and in conjunction with consultation with the patient himself.

I think with that system, Senator, we have been able to make health care services available to all patients with ESRD who really require them. The trade-off has been cost.

With the variance between the ESRD, medical information and the social security reports, my contention is I am not sure how much we really know how much it does, in fact, cost.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, Dr. Lowrie.

[The prepared statement of Dr. Lowrie follows:]

STATEMENT OF EDMUND G. LOWRIE, M.D.

SUMMARY

We have analyzed differences between the Northwest Kidney Center and Peter Bent Brigham Hospital cost estimates of home hemodialysis and the relative survival rates between home and center-based dialysis therapy. The observations are particularly germane to many provisions of H.R. 8423 and prior testimony about topics of its main concern.

Approximately two years ago the Northwest Kidney Center in Seattle estimated annual home dialysis costs to be \$6,823, exclusive of payments to a dialyzing partner. We simultaneously estimated them to be about \$16,569. The two-fold difference was staggering and taxed credibility. The Seattle group, however, has revised upward their costs for home dialysis, and a comparative analysis is described in the testimony. Our current estimate is now \$119 per treatment, while their comparable cost is \$107—only a 10 percent difference remains.

The proposed legislation encourages payment for home dialysis nurses. Adding these costs to the base increased the Seattle estimate to \$139 and ours to \$142. The comparable costs for home dialysis, therefore, are not significantly lower than the current hospital dialysis screen.

We were surprised to learn that the 3 year patient survival in Seattle was only 58 percent where 80 percent of patients are treated by home dialysis. The national average is 68 percent, and many centers report over 75 percent. Other physicians have testified to Congress that European experience shows superior home patient survival and that over 60 percent of patients are on home dialysis in England. Less than 20 percent of patients are on home dialysis in Europe, however, and they remain a highly selected group. The new patient acceptance rate in England is very low and more than three-quarters of patients who would be treated in the United States die without therapy.

The differences in the methods of health care delivery in Seattle, the remainder of the United States, England, and the remainder of Europe can be objectively summarized. Up to this point in time, most of the United States has prescribed dialysis and transplant therapy on their own medical merits as they pertain to individual patients, and has achieved acceptable patient survival while providing services to all who might benefit from them. Relatively small fractions (10 percent to 20 percent) of patients receive home hemodialysis. Europe has probably been more selective in accepting patients than the United States but, again, relatively low fractions of patients are treated by home dialysis therapy (15 percent to 18 percent). England has been highly selective in choosing patients for therapy; over $\frac{3}{4}$ of potentially treatable patients die. Seattle has apparently accepted all patients, and expended all possible efforts to place them on home hemodialysis. They have achieved inferior patient survival rates. We must conclude, therefore, that allowing patients to die untreated (as England) will permit high rates of home hemodialysis. On the other hand, accepting all patients for therapy, but placing them unselectively in the home, may lead to unacceptably high patient mortality.

Taken in their entirety, these observations indicate that promoting home dialysis by the legislative process rather than by its own medical merits may subject patients to unreasonable risks with little hope of realizing significant cost savings.

STATEMENT

I am Doctor Edmund Lowrie, assistant professor of medicine at Harvard Medical School, lecturer in chemical engineering at Massachusetts Institute of Technology, and director of hemodialysis at the Peter Bent Brigham Hospital. Doctor John P. Merrill, with other physicians at the Peter Bent Brigham, were among the first to use hemodialysis as a clinical tool, and our Department has maintained an active interest in both the costs and effectiveness of dialysis and renal transplant therapy. The goal of any therapeutic program should be first to provide the best possible form of therapy for a patient, and next to provide it at the lowest cost. These are clearly the most laudable national goals for the treatment of patients with End Stage Renal Disease (ESRD). Our analysis indicates (1) that the cost of self-care dialysis is not significantly less than limited care dialysis, and (2) the indiscriminate use of home dialysis may lead to unacceptable patient mortality.

H.R. 8423, as proposed, strongly encourages self and/or home hemodialysis throughout its text, and part (c) (4) of the proposed new section 181 sets goals for the prescription of medical therapy. Therapies should be selected on their own medical merits as applied to individual patients, and reference to goals and unreasonable incentives should be stricken from the bill. Placing such requirements in legislation literally requires an act of Congress to effect their reversal, and the political process will not allow the flexibility and speed of response required to take full advantage of a rapidly developing technical field (such as medicine) for the betterment of the Public Health.

Since the most relevant consideration in a therapeutic prescription are its effectiveness and its cost, I will discuss each consideration as it relates to dialysis therapy. Much recent debate, and the philosophy upon which much of this legislation is predicated, involves the relative cost of therapies. As such, I have chosen to discuss cost first.

Costs

It may be worthwhile to examine why previous cost estimates for home dialysis have been erroneously low. Most such estimates have been provided by physicians rather than accountants. Physicians generally devote the greatest fraction of their activities to medical care rather than accurate cost accounting. Where analyses have been performed by accountants, most data have been supplied by the medical directors of dialysis facilities rather than their accounting staffs. Many costs were hidden in grants or sequestered in other ill-defined sources of reimbursement which were not properly accounted by the medical directors furnishing data[1].

The Northwest Kidney Center, Seattle, Washington and the Peter Bent Brigham Hospital, Boston, Massachusetts submitted cost estimates for home hemodialysis to the Subcommittee on Oversight of the Committee on Ways and Means of the U.S. House of Representatives in mid-1975[2]. It is particularly appropriate to compare these two institutions because physicians in both areas were pioneers in developing hemodialysis as a clinical tool and nearly simultaneously placed the first patients in the nation on home dialysis. Seattle testified[2] the home dialysis costs were about \$38 per treatment, or \$5,931 per year after a startup cost of about \$2,675. Amortizing their initial costs over 3 years led to an estimated cost of only \$44 per treatment. Boston, on the other hand, estimated similar costs to be \$106 (\$137 if a dialyzing partner were included) [2]. The over two-fold difference taxed credibility.

Both institutions presented cost estimates to the Subcommittee on Health of Way and Means again in April, 1977[3]—less than 2 years later. The revised Seattle estimate, which includes the multiple reuse of the dialyzing filter and blood lines, increased by about 88 percent and is now \$83 per treatment, exclusive of payment to a dialyzing partner. The Brigham estimate, exclusive of payment to a dialyzing partner, increased by about 12 percent to \$119 per treatment.

A number of differences between the methods used for cost analysis in Seattle and Boston remain, however, and I have provided a detailed evaluation of these in a letter to Doctor Merrill, which is appended hereto. The attached table I summarizes the analysis.

The first item shows the initial costs. We have allowed approximately \$500 for plumbing and electricity. An explanation is contained in the footnotes to the original estimate. Seattle estimates that only \$97 is required. We note that a similar estimate from Seattle was \$250 in 1975[2].

Our training costs were assumed to be \$190 per treatment during an 8 week training period, and we believe that this reflects the national average. Seattle, on the other hand, estimated that the costs are approximately \$300 per treatment during a 3 week training period. Our startup costs apparently include additional miscellaneous equipment not accounted in the Seattle estimate, but described in our original footnotes[3].

Water costs are comparable in both cities. I note, however, that while we could not estimate electricity costs, Seattle estimated them to range between \$10 and \$120 per year in 1975.

We have adjusted Seattle's figures to net out the effect of reusing dialysis filters and blood lines, thereby making comparable the estimates. We do not reuse, but certainly if a filter can be reused in Seattle, it can be reused in Boston and if they should not be reused in Boston, they should not be reused in Seattle. Similarly, if a filter or lines can be reused in the home, they can be reused in a limited care facility—probably with greater attention to safety and sterility. The adjustment is described fully in the letter to Doctor Merrill. They use the more expensive Dow and Gambro dialyzers and their single use supply costs exceed ours somewhat.

We have included also the effects of payment to a dialysis assistant, and have employed the estimates provided by both institutions, as explained more fully in the attached letter. The inclusion of such costs is appropriate because section (a) (5) (and elsewhere) of the proposed section 181 provides for reimbursement for home dialysis personnel. Reconciling all of these costs leads to an estimate of \$142.02 per treatment in Boston and \$139.66 in Seattle. Only a 2 percent difference remains and the costs for similar home dialysis services and the medicare screen

for limited care dialysis are not substantially different. If charges for hospital and limited care dialysis continue to be reimbursed at the 80 percent rate while home charges are fully covered the cost to the Government for home dialysis could exceed that for limited care.

I will not provide a detailed discussion of in-center, self-care dialysis. To the best of my knowledge, the reimbursement rates are the same for full care, partial self-care, and self-care center dialysis. There has been no adequate accounting of the potential cost savings which might result from center-based self-care therapy. The costs for consumable supplies will be about the same for full and self-care dialysis. Facility overhead will also be similar, although the number of treatments over which it is diluted may be less in self-care centers where equipment use will be less efficient. Therefore, the only anticipated cost savings could arise from reduced patient monitoring and fewer available staff. Certainly the magnitude of the savings have not been estimated, and will probably be small. Some physicians advocate center-based, self-care while others do not, and medical opinion is clearly divided on the subject. Yet, only 1 percent of dialysis patients are receiving center-based, full self-care therapy[4]. I wonder how Congress can advocate legislatively an untested medical procedure. Many of our patients, for example, state that they would rather have dialysis staff prepare for the treatment and clean the area after its completion so that they are not required to spend an additional hour in preparation and clean up. In essence, they would rather devote that hour to personal and job activities.

Summarizing this analysis, we are confident that if Congress unreasonably promotes a form of therapy, such as home dialysis, they will 1 day be awakened by the realization that costs have again spiraled beyond original estimates. Even worse, they may 1 day realize that a form of therapy which contributes to greater patient mortality may have been encouraged erroneously.

Results of therapy—Statistical considerations

I would now like to turn to a discussion of the relative results of self-care and limited-care dialysis. Medical opinion is clearly divided on this issue. Some have pointed to the Northwest United States, indicating that they are able to place 80 percent of patients on home dialysis. In discussing their program at a recent conference a prominent Seattle physician states, "When patients first come to us, hopefully before they need dialysis, we start to persuade them that home dialysis is the best treatment", and, regarding the 80 percent figure, "Critics have argued that we are able to do this because of patient selection * * *, however, we perform no patient selection, more than 60 new patients per million are treated each year in an area with a small (5 percent) black population * * *", and, finally, "Our philosophy is that we don't discriminate. We select everybody for home dialysis, but if we don't solve the problems that arise, the patients may end up in the center"[5].

Within that same program, however, the 3 year patient survival rate is only 58 percent[3]. The national 3 year survival rate averages 66 percent to 6 percent[6, 7], and many centers report 3 year rates which exceed 75 percent[1, 8, 9]. Our own 3 year survival is 76 percent, and the survival curve is appended to the attached letter to Doctor Merrill. The only obvious reason for inferior patient survival in Seattle is the indiscriminate use of home hemodialysis therapy.

We must explore in detail, however, why Seattle experiences greater patient mortality. They have been leaders in the field, and are highly competent physicians. The quality of medical care in Seattle is above reproach, and is clearly not the issue. The observation is therefore important and reasons must be sought diligently.

Some dialysis centers may be highly selective when accepting patients for hemodialysis therapy. Seattle indicates that they accept all individuals who request and require dialysis or transplant services. Most centers in the United States have similarly liberal acceptance criteria. The median age of the dialysis population has been increasing in the United States, as shown by reports of the Dialysis Registry[6] as analyzed in Doctor Merrill's testimony to the Subcommittee on Health of Ways and Means[3] earlier this year. I believe it is fair to say that the consensus of medical literature shows that most centers offer treatment to all who require it. The median age, for example, of our center dialysis patients in Boston is 56 years.

Most centers in the United States, however, select carefully those patients to be placed on home hemodialysis, and such individuals generally have fewer medical complications and a more favorable socio-economic environment than the others. As quoted above, even Seattle places patients in the center when problems are too difficult to solve.

The European experience, as described by the European Dialysis and Transplant Association[10], indicates that approximately 29,674 patients have been accepted for hospital dialysis, and 4,505 patients (15.1 percent) have been accepted for home dialysis. In comparing the type of patients selected for each form of therapy they state, "Patients being started on home dialysis continue to be highly selected; firstly with a high male:female ratio * * * ; secondly with a high proportion of young patients * * * ". This selectivity probably accounts for the somewhat superior survival rates reported for home dialysis by the Europeans.

We reported our survival rates for home and center dialysis in 1973[11]. The survival rates at two years were 86.1 and 77.8 percent for limited care and home patients, respectively (different at the 5 percent level of confidence). The National Dialysis Registry, however[6, 7], was unable to demonstrate any significant difference between the survival of home and center dialysis patients. If patients with fewer medical complications are, in fact, placed in the home, as indicated by the European experience and the custom in most U.S. centers, one would expect superior survival in home dialysis patients, not the same, as shown by the registry, or inferior, as we found.

Some nephrologists have pointed to the United Kingdom and its home dialysis population, which is almost 65 percent of the total of all dialysis patients. Figure 1 attached hereto plots the percentage of patients on home dialysis in various European countries, as taken from Table IV of the European Dialysis and Transplant Association report[10], against the yearly new case acceptance rate per million population, taken from table XXXXII. Note England at the top of the graph with nearly 65 percent of patients at home, but accepting only 13 new patients per million population yearly. The second ranking European country is Ireland and, again, they accept only 13 patients per million. The remaining countries (Federal Republic of Germany, Sweden, Netherlands, Denmark, and France) accept slightly over 25 patients per million, and have an average of 17 percent of patients dialyzing at home. The new case acceptance for all countries are less than those in the United States, which are 40 to 60 per million.

These observations suggest that patients with renal failure from nations reporting low new case acceptance rates may be dying unnecessarily, and that selecting only the most favorable individuals permit higher fractions of home hemodialysis. In point of fact, Doctor Moorehead and his colleagues from the Department of Nephrology and Transplantation, Royal Free Hospital, London, state, "In the United Kingdom there is evidence that despite having been initially in the forefront of hemodialysis development, we are now falling behind other European countries in terms of numbers of patients treated"[12]. They go on in the same paragraph to say that a recent survey of hospital records showed that there was a rate of approximately 109 patients per million per year for terminal renal failure. Of these, 59 patients per million per year were under the age of 65, and 38 patients per million per year were under the age of 55. They considered the latter group to be probably suitable for long-term hemodialysis. They then proceed to conclude, "In fact, only about one-quarter of these patients (suitable for hemodialysis) were treated with either dialysis or transplantation over one year". This means that approximately three-fourths of potentially eligible patients in England died, and they assumed a low age cutoff of 55 years. Do we propose this system of health care delivery for Americans? Our median age for dialysis patients exceeds 51 years, and our new case rate in the United States is twice that reported from most other countries. These facts prove that nearly all individuals who require care for terminal renal failure have access to that care regardless of age, race, religion, education, or socioeconomic status.

Some physicians have testified that Canada is able to achieve a 40 percent home dialysis prevalence. Canada is far different from the United States, however. The Canadian Renal Failure Registry has not published a recent report but has performed surveys in 1975 and 1976. There are only about 60 dialysis facilities and 22 transplant units, and only 1,915 patients were receiving dialysis therapy [13]. Approximately 30 percent of these patients were dialyzed in the home, and the estimated new case rate is about 30 per million [13]. Average ages were not available, but the new case rate is similar to that reported from the Federal Republic of Germany, Switzerland, and other countries shown in the lower margin of Figure 1. Canada is currently experimenting with self-care dialysis, and approximately 2 percent of the dialysis population are treated in this way.

The differences in the methods of health care delivery in Seattle, the remainder of the United States, England, and the remainder of Europe, can be analyzed and

objectively summarized. Up to this point in time, most of the United States has prescribed dialysis and transplant therapy on their own medical merits as they pertain to individual patients, and has achieved acceptable patient survival while providing services to all who might benefit from them. About 10 percent to 20 percent of patients receive home hemodialysis. Europe has probably been more selective in accepting patients than the United States, but the prevalence of home hemodialysis is similar to that of the United States. England has been highly selective in choosing patients for therapy, and up to three-fourths of potentially treatable patients die from their disease without receiving the needed treatment. Seattle has apparently accepted all patients, and expended all possible efforts to place them on home hemodialysis and has achieved inferior patient survival rates. We must conclude, therefore, that allowing patients to die untreated (as England) will permit high rates of home hemodialysis. On the other hand, accepting all patients for therapy, but placing them unselectively in the home, may lead to unacceptably high patient mortality.

I have not touched on many of the other problems which may arise from home dialysis, such as conflicts between marital partners, depression in the children of home patients, guilt reactions in patient and spouse, less careful monitoring of dialysis technique and equipment, and delayed detection of medical abnormalities. It is sufficient to say that they do exist and cannot be dismissed. We submit that Congress should not legislatively encourage any particular form of therapy—particularly when all of the relevant factors have not been thoroughly evaluated. This system for health care service has evolved to a very high level based primarily on the relative medical merits of all available therapeutic forms. The theorized cost controlling measures contained in H.R. 8423 will not serve their primary purpose and will compromise the quality of medical care in the United States.

Thank you for allowing me to testify on a subject which is most important to patients and physicians involved in the receipt and provision of medical services. I have tried to provide a quantitative overview of some important aspects of health care delivery to ESRD patients. I have also attempted to provide background material by which statistical facts stated in previous testimony may be interpreted in light of their entirety. In so doing, I submit herewith a list of appropriate reference material from which these facts were extracted and by which they may be validated. I will be happy to answer any questions. Thank you.

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13. Personal Communications, A. Shimizu, Chairman, Canadian Renal Failure Registry, October 14, 1977.

TABLE I.—COMPARABLE COST ESTIMATES OF HOME HEMODIALYSIS IN SEATTLE AND BOSTON¹

	Boston		Seattle	
	Average cost	Per Rx	Average cost	Per Rx
Initial cost:				
Plumbing	400		97	
Electricity	100			
Training	4,940		2,739	(²)
Related physician fee	500		500	
Miscellaneous startup costs	1,681		750	
Total	7,621		4,086	
Direct cost:				
Amortization of initial cost (over 3 yr)	2,540	16.28	1,362	8.73
Water	600	3.85	552	3.53
Supplies	7,050	45.19	8,502	³ 54.50
Equipment rental	3,960	25.38	2,172	13.92
Physician fees	1,512	9.69	1,512	9.69
Equipment maintenance	300	1.92	343	2.20
Routine laboratory (at \$3 per Rx)	423	2.71	423	2.71
Hospital or limited care	2,250	14.42	1,932	12.38
Total	18,635	119.44	16,798	107.66
Indirect cost: Tax loss (to Federal Government)	139	.89		
Subtotal	18,774	120.33	16,798	107.66
Option: Use of dialysis assistant salary	3,384	21.69	4,992	32.00
Grand total	22,158	142.02	21,790	139.66

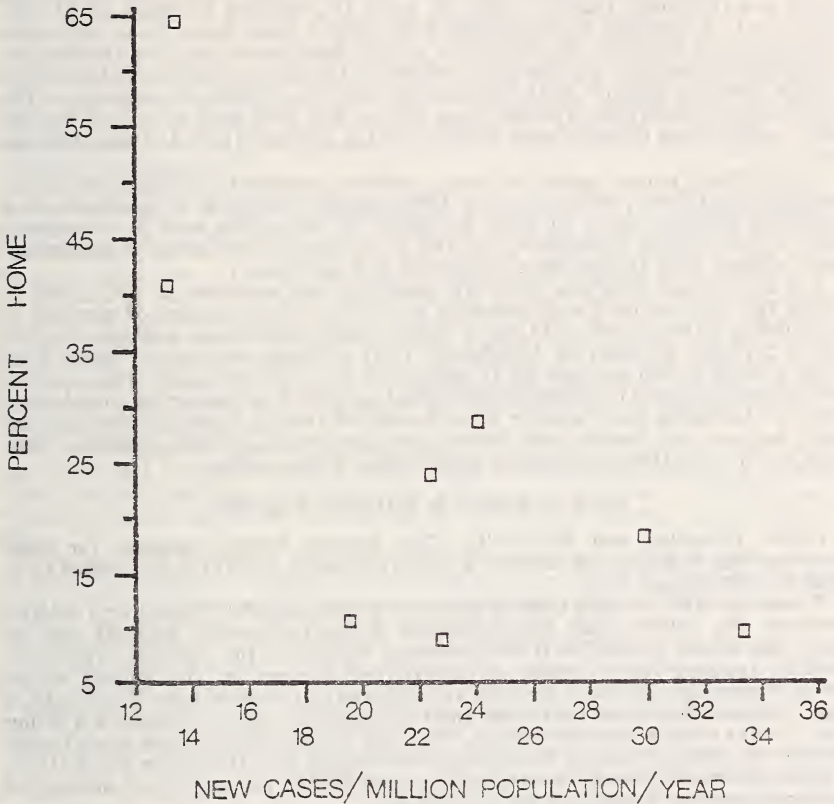
¹ Taken from hearings before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, 95th Cong. 1st sess. on H.R. 3112, Apr. 25, 1977, pp. 135-137 and pp. 237-239. Footnotes to these original documents apply as recorded therein except as otherwise stated.

² Boston assumes a 2-mo training time at \$190 per treatment (the Medicare screen). Seattle assumes 3.09 week training time at an average cost of \$295 per treatment if treatments are provided 3 times weekly.

³ The Seattle supply costs have been revised upward to net out the effects of reuse for reasons stated in a letter to Dr. J. P. Merrill which is appended to testimony. The Brigham costs include provider mark-up, the Seattle costs do not.

Figure 1

PERCENT OF PATIENTS ON HOME DIALYSIS
AND THE NEW CASE ACCEPTANCE RATE IN
EUROPE



PETER BENT BRIGHAM HOSPITAL,
Boston, Mass., October 6, 1977.

JOHN P. MERRILL, M.D.,
Director, Renal Division,
Peter Bent Brigham Hospital,
Boston, Mass.

DEAR DR. MERRILL: As you know, hearings on H.R. 3112 were held before the subcommittee on Health on April 25th[1]. Doctors Belding Scribner and Eugene Schupak debated during these proceedings and Doctor Scribner questioned the validity of the Peter Bent Brigham Hospital estimate of home dialysis costs,

stating that they were less than \$10,000.00 per year in the State of Washington. He requested and was granted permission to review, document, and submit for the record the actual costs as experienced by their home dialysis program. Doctor Christopher Blagg of the Northwest Kidney Center submitted for the record the documentation on May 13, 1977.

We are pleased to note that his cost analysis, with some exceptions, is similar to our own and the gap between estimates from the two institutions has narrowed substantially since similar hearings approximately two years ago[2]. At those hearings their costs for home dialysis were reported to be approximately \$38.02 per treatment (Ref. 2; Page 60, table IV, enclosed herewith as Attachment I-A). Amortizing their start-up costs over 3 years leads to an estimated annual cost of \$6,822.79, or \$6,880.32 if certain noncovered supplies (electricity, water and nonmedical supplies) are included. During the most recent hearings Doctor Scribner affirmed that the average cost for all dialysis patients in the Northwest was less than \$10,000.00 per patient and that both home and "higher cost" center-based patients were included in the average (Ref. 1; Pages 116 and 131).

Doctor Blagg's most recent analysis, however (enclosed at Attachment I-B), indicates that their costs for home hemodialysis, exclusive of payments to a dialyzing partner, were, in fact, \$12,928.00 in 1976. The sum is 29 percent greater than Doctor Scribner stated and is 68 percent (exclusive of physicians' fees) greater than Doctor Blagg's estimate of 2 years ago.

The Peter Bent Brigham Hospital submitted cost estimates in 1975 (Ref. 2, Pages 146-148; enclosed as attachment I-C). The costs, exclusive of payment to a dialyzing partner, were \$16,569.00. The currently submitted analysis (Ref. 1, Pages 237-239; enclosed as Attachment I-D) estimate comparable direct costs to be \$18,635.00—an increase of 12 percent in the past two years. The previous discrepancy between our analyses disturbed me and it is reassuring to note that they are becoming more similar with thoughtful review. Certain differences remain between the Seattle and Boston estimates which require comment, however, and I will attempt to discuss briefly some of these below.

COSTS EXCLUSIVE OF DIALYZING PARTNER

Initial Plumbing and Electricity.—The current Seattle estimate for these modifications is \$97.00 per patient. A similar estimate in 1975 was reported to be \$250.00 (Attachment I-A).

Training.—The training time in Seattle is approximately 3 weeks, or 9 dialysis sessions. We believe that this represents a low nationwide estimate and, as such, one should generalize it with extreme caution to the national experience. Median training times should be determined throughout the United States prior to assuming that only 3 weeks are required in the usual case. The length of many training programs for nurses and technicians in which exposure is 5 rather than 3 days weekly exceeds 3 weeks. Why else would some consider special certification for dialysis nurses. We note parenthetically that if patients are dialyzed 3 times per week, Seattle training costs exceed \$300.00 per session—a substantial variance from the established screen of \$190.00.

Miscellaneous Startup Costs.—Our miscellaneous startup costs exceed those reported in 1975. The primary reason is ascribed to the current inclusion of certain devices not previously supplied. The Seattle estimates are similar to or slightly less than previously reported.

Water and Electricity.—Cost for water are similar in the two areas. We note with interest, however, that the original Seattle analysis showed electricity costs were approximately \$12.50 per year in 1975 and estimated them to range between \$10.00 and \$120.00 per year nationally (see attachment I-A).

Supplies.—Doctor Blagg's estimated supply costs are \$4,680.00, in contrast to our \$7,050.00. Although Dow and Gambro dialyzers (his example) are more expensive than coils (our example, the difference, he states, is because Seattle reuses dialyzers and tubing sets. We do not reuse in the home for several reasons. One cannot force a patient to reuse, and coils are seldom reused. Manufacturers do not certify dialyzers for reuse and state that they are intended for one use only. I have enclosed as Attachment II the package literature from Cordis Dow and Gambro.

Manufacturers are reluctant to assume the liability for use of a potentially contaminated, reused dialyzer. They have no control over the reuse procedure and patients in the home cannot be considered to be experts in techniques of

sterilization. Further, the responsible dialysis facility has no control over the methods used by the patient in the home, should they elect to somehow "short-cut" or alter the sterilization procedure. The limits of the liability for reuse are poorly defined, and Congressman Vanik recognized this problem. During his introduction of H.R. 3112[3], he stated, "Today filters are generally thrown away after one use, which does have the advantage of eliminating some of the dangers of infection, hepatitis, and so forth, from improperly cleaned filters". He then goes on to suggest that use be limited to the less expensive types of dialyzer rather than solve the problem of indemnifying physicians, providers and manufacturers from possible adverse effects to patients from dialyzer reuse.

We do not wish to assume a position against reuse and feel that it is safe when performed by trained individuals in a controlled setting. However, if one is to compare analytically home dialysis costs to center costs, one cannot reasonably apply reuse to reducing home costs without using similar procedures to reduce center costs. Dialyzers can probably be more safely reused and resterilized within a center than in the home. Specialized equipment is available to support reuse and technicians trained in the procedure sterilize the kidney in a controlled and monitored environment.

We have attempted to make more comparable with our own the Seattle estimate by netting out the effect of reuse. In his 1975 testimony, Doctor Blagg stated that dialyzers are reused from 3 to 6 times (Attachment I-A). We have assumed a mid-range value of 4.5 times for the purposes of these adjustments. The most commonly used type of Dow kidney sells for \$323.40 per case of 12 if sold in lots of 1 to 5 cases. If sold in lots of 25 cases or more to providers, the price is \$275.40 per case, or \$22.95 per unit. Arterial lines sell for \$87.60 per case of 24 when bulk-purchased in lots of 10 or more cases. Venous lines sell for \$68.00. Therefore, a Dow dialyzer with arterial and venous lines, when bought in bulk by a provider will cost \$29.40. Assuming the dialyzer and lines were reused 4.5 times, the average cost of lines and dialyzer at the Northeast Kidney Center would be \$6.54, exclusive of reuse costs.

Doctor Blagg states that the average supply cost is \$30.00 per treatment. Netting the reused dialyzer from the total supply cost yields an expense of \$23.46 "other" dialysis supplies. If the dialyzer were not reused, the cost of dialyzer and lines (\$29.40) added to the non-dialyzer costs yields \$52.86, or \$8,246.16 per year.

Many facilities who reuse Dow and Gambro dialyzers are able to achieve reuse rates which approach or exceed Doctor Blagg's upper limit of 6. If the actual reuse is closer to 6 than 4, the single use cost could increase to \$8,502.00 per year—or \$54.50 per treatment with no provider markup for supplies.

Equipment Rental.—The Northwest Kidney Center estimates for equipment leasing and rental are less than our estimates. It may well be that reuse of older or fully depreciated equipment or purchase of other less expensive equipment may be somewhat cheaper than renting directly equipment from the manufacturer. The difference in estimates is approximately \$11.00 per treatment.

Physicians' Fees.—The difference between the two estimates suggest that physicians' fees in Seattle are approximately \$228.00 per year less than similar fees in Boston. In comparing this difference should be accounted. The fees may rise in Seattle if physicians elect to net out the alternate method fee and charge separately during a period of hospitalization as allowed by regulation.

Therefore, if appropriate adjustments are made for reuse (without including the cost of reuse) and if physician costs are made comparable by increasing upward the Seattle cost by \$228.00, their total annual cost for home dialysis would be \$16,722.00 (\$107.00 per treatment), exclusive of payment to a dialyzing partner. Our comparable estimate is \$18,635.00 (\$119.00 per treatment) and theirs is now only 10 percent less than ours.

COSTS INCLUDING DIALYSIS NURSES

We disagree with our colleagues from the Northwest when they state that it is not appropriate to include the cost of a home dialysis helper in this analysis. To the contrary, much consideration has been given to include payment for a home dialyzing partner in the benefit package and to exclude such payments from consideration may lead to a gross error in judgment. It would be naive to assume that patients would not take advantage of this benefit if it were offered. What physician would refuse to certify for his patient a home dialysis nurse for some medical or social reason if requested by the patient? I suspect that most who say "T" have had little recent, intimate exposure to patients.

We purposefully included a low estimate of home nurse costs (see our Footnote ii, Enc. I-D). Most nurses charge \$40-\$60 (benefits not included) per treatment when "moonlighting" and the liabilities of using unlicensed personnel are not clear. Doctor Blagg's helper costs are stated in the footnote to his second table in Attachment I-B. If we add a home helper to the single use estimate from Seattle, the total cost increases from \$107.00 per treatment to \$129.00 and \$139.00 for a partial and complete helper, respectively. The latter is very similar to our estimate of \$142.00. Therefore, the comparable estimates from Seattle and Boston are in close agreement and they are not significantly less than the in-center screen, as we stated in our letter to the Massachusetts Kidney Foundation (Ref. 1, pp. 237-239).

AMORTIZATION OF COSTS

The Northwest Kidney Center believes that the startup costs should be treated as first year expense, but we submit that the most acceptable accounting practice is to amortize such expenses over an anticipated useful life. The three year survival rate for all patients in the Northwest Kidney Center program is only 58 percent. If we assume that the 3 year survival of home patients is 58 percent and consider that there will be additional losses to the home program because of transplantation and return to center dialysis, it would be reasonable to consider that the median residence time in home dialysis to be 3 years or less. Therefore, the initial costs in Seattle should probably be amortized over 3 years or less, and 3 is certainly reasonable.

PATIENT SURVIVAL

I was somewhat surprised to note that the 3 year survival rate for patients in the Northwest Kidney Center program is 58 percent. The national average for all patients is said to be about 68 percent[4]. We are now reviewing our own experience, and I enclose as Figure 1 a curve which compares the survival of patients presenting with severe uremia to those with less severe complications. I chose this comparison because there was no difference between the groups, and I do not have easily at hand a single graph. The lines indicate actual data, while the symbols indicate a log-linear best fit. The 3 year survival rate is 76 percent, which includes home, center, and aged patients, as well as those with complicating illnesses such as diabetes and malignancy. I believe that others, such as the Southwestern Medical Group of the University of Texas, experienced similar or superior rates of survival to our own.

I am fully cognizant of the medical expertise of my colleagues in Seattle and recognize the great contribution they have made to our field. In analyzing potential differences, I note that 80 percent of patients in Washington are on home dialysis (Dr. Scribner's testimony; Ref. 1, p. 116), while only about 20 percent of ours are so treated. Few programs in this country select against the infirm or the aged, and there is no question about the technical capabilities of most dialysis programs who bother to analyze and report their data. While most studies fail to show a difference between the survival rates of home and center dialysis patients, most programs tend to place healthier patients and those with reasonably stable home setting in the home. Such, for example, was the experience noted by some authors in discussing their work[5].

In the aggregate, then, one should see better survival in home patients simply because most programs select less complicated cases for home dialysis. If, however, a group of competent physicians place virtually all patients in the home (therefore with less technical and medical supervision) and experience inferior survival, it may well be that selecting for home dialysis by the legislative process may also subject patients to an unreasonable risk with no hope of realizing a significant cost savings.

We feel that the analysis provides a worthwhile comparison, illustrating amply that the costs of home dialysis are, in fact, similar in Seattle and Boston. They are substantially higher than most people think and most previous estimates of home dialysis costs have been erroneously low due to incomplete analysis or reporting. We hope that future judgements will now be based on factual rather than erroneous estimates of cost information.

Very sincerely yours,

EDMUND G. LOWRIE, M.D.,
Director, Hemodialysis Unit.

REFERENCES

1. Hearing before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, 95th Congress, First Session, on H.R. 3112, April 25, 1977.

2. Hearings of the Subcommittee on Oversight of the Committee on Ways and Means, House of Representatives, 94th Congress, First Session, June 24th to July 30th, 1977.

3. Congressional Record, February 3, 1977.

4. Sixth Annual Report of the National Dialysis Registry, Figure 5, page 34, October, 1974.

5. Parsons, F., Brenner, F., Gurland, H. et al: Combined Report on Regular Dialysis and Transplantation in Europe; Discussion, Proc. EDTA, Vol. 8, page 28, 1971.

[From testimony of Northwest Kidney Center, Seattle, Washington, before the Subcommittee on Oversight of Ways and Means, June, 1975, p. 60 61]

ATTACHMENT I-A

3. *Question.* How much does it cost the patient for one session of home dialysis?

Answer. During 1974, the cost per home dialysis at the Northwest Kidney Center, based on an analysis of 112 patients, was \$38.02. (Table IV) This includes supplies (disposable dialyzers are reused three to six times), water treatment, laboratory charges, equipment service, and equipment rental, but excludes physicians services, training costs, and the cost of home modifications.

TABLE IV—Cost of home dialysis in Seattle, based on 112 patients treated during 1974

	Per dialysis
Supplies -----	¹ \$24. 00
Water treatment-----	3.33
Laboratory -----	. 73
Equipment servicing-----	2. 04
Equipment rental-----	7. 92
Total -----	38. 02
One time costs not included in above:	
Addition and cost of training-----	\$1, 625
Plumbing and electrical modifications-----	250
Cost of minor equipment-----	800

¹ Includes dialyzer reuse 3-6 times.

Question. How much would it cost the same individual if he was dialyzed in your hospital or clinic?

Answer. \$148.00 excluding physician fees.

4. *Question.* How much does one of your home dialysis patients spend out of his own pocket each year on extras that Medicare does not cover, but would cover if the same patient was dialyzed in a hospital or clinic (electricity, the labor of a family member aiding the dialysis procedure, plumbing, and those drugs that if administered by a physician are covered by Medicare)?

Answer. Electricity—the cost for each dialysis in Seattle is approximately 8¢, or \$12.48 per year. Nationally, this cost could vary from \$10-120 per year.

Water—the cost for each dialysis in Seattle averages 7¢ or \$10.63 per year. Nationally these costs probably would average \$10-30 per year.

Non-medical supplies including Lysol, Chlorox, alcohol, hydrogen peroxide, and paper towels average \$0.22 per dialysis, or \$34.42 per year.

[Hearings before the Subcommittee on Health of Ways and Means April 177, pp. 135-137]

ATTACHMENT I-B

NORTHWEST KIDNEY CENTER,
Seattle, Wash., May 13, 1977.

Congressman DAN ROSTENKOWSKI,
Subcommittee on Health, House Ways and Means Committee, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROSTENKOWSKI: At three recent hearings on H.R. 3112, figures were presented on the cost of dialysis at home based on experience of the Peter Bent Brigham Hospital in Boston. These figures were the subject of debate between Drs. Scribner and Schupak regarding the cost of home dialysis. Consequently, I have analyzed our data from the Northwest Kidney

Center for 1976 in the same fashion as the Brigham data, and am sending the enclosed copy to you. I hope that this can be entered into the record.

With many thanks for your continuing interest in the End-Stage Renal Disease program.

Sincerely yours,

CHRISTOPHER R. BLAGG, M.D., *Director.*

Enclosure.

COST OF DIALYSIS AT HOME, BASED ON EXPERIENCE AT NORTHWEST KIDNEY CENTER, SEATTLE, 1976, ON 260 HOME DIALYSIS PATIENTS

	Average cost	⁴ Average cost per Rx
Initial cost:		
Plumbing, electricity.....	¹ 97	-----
Training.....	² 2,739	-----
Related physician fee.....	³ 500	-----
Miscellaneous startup costs.....	³ 750	-----
Total.....	4,086	-----
Direct cost:		
Amortization of initial cost over 3 yr.....	1,362	\$8.73
Water.....	⁵ 552	3.53
Supplies (141 Rx at \$50).....	⁶ 4,680	30.00
Equipment rental.....	⁷ 2,172	13.92
Physician fees.....	⁸ 1,464	9.38
Equipment maintenance.....	343	2.20
Routine laboratory (at \$3 per Rx).....	423	2.71
Hospital or limited care backup.....	⁹ 1,932	12.38
Total.....	12,928	82.86

¹ Actual costs for home modifications involving plumbing and electricity.

² Based on actual training costs. Currently, training time averages 3.09 weeks; this includes all costs for training, except the \$500 physician fee.

³ Includes all miscellaneous equipment required for home dialysis.

⁴ Costs for home dialysis and a figure of 14 backup dialysis treatments per patient per year are used, based on actual experience.

⁵ Water treatment costs are based on actual experience in Western Washington. Information is not available on increased electrical expenses.

⁶ This represents actual costs. All patients purchase supplies through the Northwest Kidney Center. All patients use Dow Cordis or Gambro dialyzers, but the vast majority (95 percent plus) of patients reuse their dialyzers and tubing sets several times, so reducing the overall cost.

⁷ This is the average cost of equipment rental in our program. The Northwest Kidney Center purchases equipment from the manufacturer, and then leases this to the patient.

⁸ Based on the "alternate method" of Medicare reimbursement, i.e., a monthly capitation fee. This is based on actual experience in this region.

⁹ Our experience is that home dialysis patients average 14 backup dialysis treatments per year, most of which are performed in a limited care facility, and relatively few in hospitals. A rate of \$138 per treatment is used because physicians reimbursed by the alternate method do not charge a physician fee for outpatient dialysis.

Note. These estimates are based on actual costs for an average of 260 patients being treated by home dialysis through the Northwest Kidney Center during 1976, and consequently are derived from a greater number of patients and over a longer period of time than the figures given by Dr. Scribner on p. 144 of his testimony.

Indirect cost

Tax Loss to Federal Government—Not estimated.

OPTION—USE OF PAID HELPER—USED BY 10 PCT OF PATIENTS¹

	Average cost	Per dialysis
Use of dialysis assistant salary—full helper.....	\$4,992	\$32.00
Total.....	17,920	114.86
If helper costs spread over whole program.....	245	1.57
Total.....	13,173	84.43

¹ The option of the use of a dialysis helper should not be included in the routine cost of home dialysis. To include this in the "Grand Total" as the Brigham figures do, is misleading. Presently 10 percent of our patients have paid home dialysis helpers, and these are classified as minimal, partial, and complete helpers. Approximate charge for their services is \$15, \$22, and \$32 per dialysis. Among the 260 patients, 6 had minimal helpers, 4 had partial helpers, and 16 had full helpers.

COMMENTS

(1) The appropriateness of including the amortized cost of the initial training in the annual cost for home dialysis can be questioned. The Brigham figures

amortize this over three years, but in the Northwest Kidney Center program the three year survival of dialysis patients is 58 percent. (This includes diabetics and all long-term in-center as well as home dialysis patients). Consequently, we believe it more appropriate to include the initial cost in entirety in the first year cost of home dialysis. This would mean that the first year cost of home dialysis is roughly comparable to the annual cost of outpatient dialysis, but annual costs thereafter would provide a more direct comparison of the actual cost of home dialysis (\$11,566 when initial cost is excluded), and outpatient in-facility dialysis (\$23,400).

(2) The cost of out-of-hospital in-facility dialysis at \$150 per treatment is \$23,400 per year (this includes physician's fee). However, approximately 50 percent of all long-term dialysis patients in this country dialyze as outpatients in hospital facilities, and many of these hospitals have an exception from Medicare to charge more per dialysis than the screen level. Thus, the national average cost for outpatient dialysis probably is appreciably greater than \$23,400 per year.

(3) The magnitude of cost saving with home dialysis, while of obvious importance, is only one of the several advantages of home dialysis. Other advantages of home dialysis were discussed in the testimony of both physicians and patients at the hearings.

[From Dr. E. Lowrie, Peter Bent Brigham Hospital, Boston, Mass. Hearings before the Subcommittee on Oversight of Ways and Means, June 1975, pp. 146-148]

ATTACHMENT I-C COST OF HOME HEMODIALYSIS

	Average cost	Average cost per dialysis
Initial costs (nonrecurring):		
Plumbing	\$400	
Electricity	100	
Training	3,950	
Related physician fees	800	
Dialysis machine	4,000	
Miscellaneous products	400	
Total	9,650	
Amortized over 3 years, assume 141 treatments at home	3,217	\$22.81
		Average cost per dialysis (includes all treatments equals 156 per year)
Direct costs (with each treatment):		
Water	\$600	
Supplies (at \$42 per treatment)	5,922	
Physicians fees (at \$140 per month)	1,680	
Maintenance	300	
Laboratory	350	
Hospital backup	4,500	
Total	13,352	\$85.59
	Average cost per year	Average cost per dialysis
Indirect costs (and/or economic):		
Dialysis assistant	4,525	
Tax cost	600	
Total	4,125	\$29.26
Total costs	20,695	137.86

¹ Plumbing costs vary from \$300 to \$1,000. This number represents a low average estimate. In several instances additional capacity to heat water has been installed at obviously greater costs.

² This represents a conservative estimate for the sum total of dialysis equipment, including the dialysate delivery system blood pump, and supporting equipment. Similar equipment may be leased for an average annual cost of \$1,500.

³ Water treatment concerns in this area rent deionizers for approximately \$45 per month. Each patient will use approximately 7,000 gals of water per year. We have no similar data for increased electrical costs.

⁴ We have accounted time lost by the dialysis assistant to be valued at approximately \$25 per treatment.

⁵ A patient is entitled to a legitimate tax deduction from the Internal Revenue Service if his home is used for medical purposes. In addition, valid depreciation and damage occurs from spillage, machine casters, et cetera.

[Hearings before the Subcommittee on Health of Ways and Means, April 1977, pp. 237-239.]

ATTACHMENT I-D

COST OF DIALYSIS AT HOME: BASED ON EXPERIENCE AT PETER BENT BRIGHAM HOSPITAL, BOSTON

	Average cost	Average cost per Rx ⁴
Initial cost:		
Plumbing.....	1 \$400	
Electricity.....	100	
Training (2 mo at \$190 per Rx).....	2 4,940	
Related physician fee.....	2 500	
Miscellaneous startup costs.....	3 1,681	
Total.....	7,621	
Direct cost:		
Amortization of initial cost over 3 yr.....	2,540	\$16.28
Water.....	600	3.85
Supplies (141 Rx at \$50).....	7 7,050	45.19
Equipment rental.....	7 3,960	25.38
Physician fees.....	8 1,512	9.69
Equipment maintenance.....	300	1.92
Routine laboratory (at \$3 per Rx).....	423	2.71
Hospital or limited care backup.....	9 2,250	14.42
Subtotal.....	18,635	119.44
Indirect cost: Tax loss to Federal Government.....	1 159	.89
Subtotal.....	18,774	120.33
Option: Use of dialysis assistant salary.....	11 3,384	21.69
Grand total.....	22,158	142.02

¹ As noted in our original study, plumbing costs vary from \$300 to \$1,000. The \$400 estimate represents a low average cost. It should be noted that in many instances additional capacity to heat water is installed at greater costs.

² Medicare allows up to \$150 per treatment, but some centers find it more expensive and have requested and been granted exemptions to this screen. Two months of training (26 treatments) is our low average time required in order to adequately and safely instruct the patient. Physician fee is included in the \$190, except for a \$500 bonus allowable by Medicare at the completion of training.

³ Includes scale, hematocrit machine, blood pressure supplies, access supplies, bubble detector and negative pressure sensor.

⁴ Assumes 141 treatments at home (90 percent) and 15 treatments in the hospital or other limited care facility—156 treatments per year.

⁵ Water treatment companies in the Boston area rent deionizers for approximately \$45 per month. Water use may vary somewhat but is about 7,000 gallons per year. We have no data on increased electrical expenses.

⁶ Represents a mid-range to conservative estimate for a "coil kit" used by some of our patients. It should be noted that the Peter Bent Brigham Hospital and other facilities have an allowable markup of 20 pct to cover handling. Therefore, a kit selling for \$43 (Baxter Travenol kit with UF-11 dialyzer) is distributed for approximately \$51.60. It should be noted that other commonly used dialyzers (i.e., Dow Cordis, Gambro, et cetera) will cost substantially more than \$50 for a "kit".

⁷ This represents the average price for the most commonly used model (i.e., Drake Willcock system) at \$330 per month. Other systems vary somewhat. A "guideline" for reimbursement states that "large" items may be rented for 1/18 of the selling price per month and "small" items at 1/10 of the selling price per month.

⁸ Based on the "alternate method" of Medicare reimbursement, i.e., monthly capitation fee. We have assumed a physician profile of \$10 which yields \$140 per month capitation fee. Physician profiles may vary between \$8 and \$12, as allowable by Medicare, and ours represents an average to low estimate. Physician fees for limited care or hospital dialysis are included in the \$150 total charge.

⁹ We have assumed that 10 percent of the dialysis treatments will be performed in a hospital or limited care facility (illness, vacation of spouse, traveling, et cetera) at a rate of \$150 per treatment, which includes physician fee. The estimate is conservative as hospital costs may be substantially more.

¹⁰ A patient is entitled to a deduction from his Federal income Tax return if his home or apartment is used in part for medical purposes. These deductions (tax effect) are real costs to the government and should be considered. We have assumed two alternatives and have averaged them:

(a) \$40,000 value of a home with 8 rooms, 40-yr amortization, 1 room used for dialysis. Therefore: \$1000 depreciation per year (\$40,000 divided by 40-yr), $\frac{1}{2}$ will be deductible, and for an individual in the 33 percent tax bracket, will mean \$41.25 lost to the government as tax each year.

(b) 5-room apartment at \$300 per month, 1 room used for dialysis. Therefore: $\frac{1}{2}$ of \$300 per month will be deductible. The sum will represent approximately \$237 lost to the government in tax revenue for an individual in the 33 percent tax bracket.

The estimate assumes $\frac{1}{2}$ are owners and $\frac{1}{2}$ are renters. Therefore, the estimated average tax loss to the government will be approximately \$139 per home dialysis patient.

¹¹ The local average salary for dialysis technicians is \$160 per week, or approximately \$4 per hour, without fringe benefits. Assume 6 hr per dialysis, including assembly and cleanup time, and no additional charge for malpractice insurance (if available) or portal to portal pay. It should also be noted that if nurses or LPN's are used, the cost will likely double.

The estimate was procured by multiplying the hourly rate by 6 hr and multiplying that product by 141 treatments per year. The resulting value was diluted over 156 treatments per year.

We should further note that the weekly income for a technician participating in such a program would be \$144 per week without portal to portal or fringe pay, which is less than a similarly trained individual would make for a 5-day work week in a hospital or limited care facility.

ATTACHMENT II-A

INTRODUCTION FOR PREPARING THE C-DAK ARTIFICIAL KIDNEY FOR DIALYSIS

(This instruction sheet is provided as an aid to achieving satisfactory dialysis results with the C-DAK Artificial Kidney. It is intended that the operator will have completed a thorough training program in dialysis and the use of the C-DAK Artificial Kidney. (Refer to the appropriate C-DAK Manual). The procedure described in this instruction sheet is intended for C-DAK Artificial Kidneys which are sterilized with an aqueous solution containing formaldehyde and supersedes all previous instructions for preparation and use of the C-DAK Artificial Kidneys.)

INDICATIONS

Hemodialysis is indicated for patients with acute, or chronic renal failure, when conservative therapy is judged to be inadequate.

CONTRAINDICATIONS

There are no absolute contraindications to hemodialysis therapy recognized by the medical community.

WARNINGS AND PRECAUTIONS

1. This dialyzer is intended for one use only. Do not reuse.
2. Side effects such as hypertension, hypotension, headache and nausea which may be associated with dialysis can usually be avoided by careful management of the patient's fluid and electrolytic balance, blood flow rate and transmembrane pressure. Other complication such as blood loss, hemolysis, excessive ultrafiltration and electrolyte imbalance have been associated with equipment malfunction or procedural error associated with hemodialysis.
3. The blood pathway of this dialyzer is sterile and non-pyrogenic in an unopened, undamaged bag. Do not use if the bag is received open or the blood port caps are missing. An aseptic technique is required to avoid contamination of the blood path when connecting the blood lines and patient to the dialyzer.
4. This dialyzer is sterilized with an aqueous solution containing formaldehyde. Care must be taken to insure that the formaldehyde solution is flushed from the dialyzer prior to use. Possible adverse reactions can occur to patients infused with formaldehyde. Refer to instruction manual for detailed setup and rinse procedure.
5. Do not exceed a transmembrane pressure of 500 mm Hg with this dialyzer.
6. All connections must be checked carefully prior to and during the first minutes of operation. At several times during dialysis there should be visual inspection of the connections to detect leaks and avoid blood loss.
7. Warning: Air entering the extracorporeal blood circuit, if undetected, may cause fatal air embolism. The use of an air/foam detector is recommended at all times. Air return of blood to the patient at the termination of dialysis is not recommended due to the increased chance of air embolism to the patient.
8. Cordis Dow Artificial Kidneys can be damaged by high or low temperature. Suggested ambient temperature range is 32°F. (0°C) to 100°F. (38°C).
9. If tap water is used to rinse the C-DAK, be sure that the fluid in the dialysate and blood compartments is within proper dialyzing limits before initiating dialysis.
10. Although this dialyzer has been tested for mechanical integrity, there is a possibility that a leak may occur during dialysis leading to blood loss. Therefore constant monitoring by means of a blood leak detector in the dialyzing fluid line of the dialysis machine is recommended.

Frequency and duration of treatment is to be determined by the prescribing physician.

Caution: Federal (U.S.A.) law restricts this device to sale by or on order of a physician.

Data	El	Lena A		Miua	MM
Surface area	1.5m ¹	1m ¹	1m ¹	0.54m ¹	0.24m ¹ .
Number of layers	25	17	17	9	4.
Membrane thickness	13.5	13.5	17	17	17 micron.
Priming volume	200 ml.	120 ml.	90 ml.	43 ml.	25 ml at a gradient of 45 mm Hg.
Residual blood volume	<8 ml.	<4 ml.	<4 ml.	<2 ml.	

ATTACHMENT II-B

The Gambro Lundia are disposable parallel flow dialysers. The membrane used in the dialyser is Cuprophane® with a thickness of 13.5 or 17 micron. The dialyser is available in 5 different designs as described above.

The dialysers can be used at different flowrates in single pass systems as well as in recirculating and closed loop systems. To obtain optimal performance, the Gambro Lundia should be used in the vertical position—arterial end up with counter-current dialysate flow. See "Dialysing with the Gambro Lundia Dialysers". The Gambro Lundia dialysers are intended for use with Gambro blood lines. For closer information on the Gambro blood lines, please contact your Gambro representative.

CLEARANCE

The Gambro Lundia dialyser can be used on a high efficiency rapid dialyser or as truly passive flow dialysis instrument. Typical efficiency graphs are shown in fig. 1 below.

Clearance ml/min in vitro

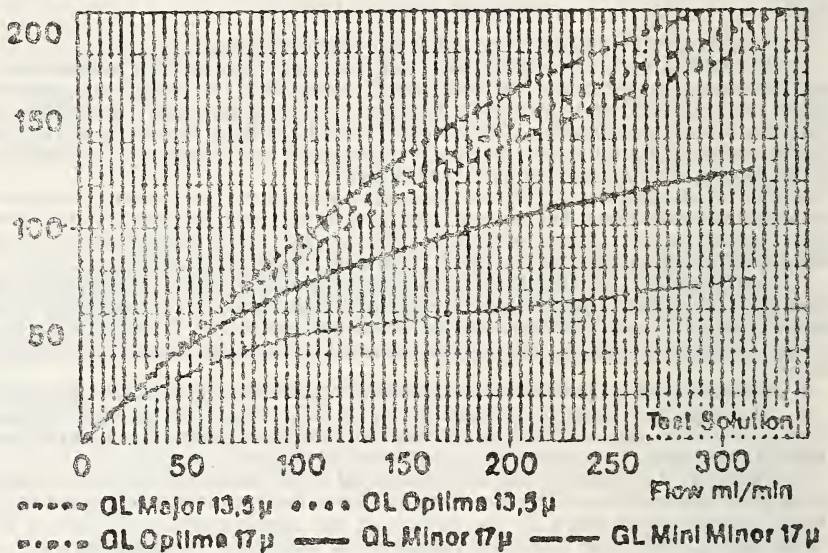


FIGURE 1.—Clearance in vitro of Urea of the four Gambro Lundia Optima dialysers at a dialysate flow of 500 ml/min.

ULTRAFILTRATION

Ultrafiltration performance of a dialyzer is usually by the staff and the patients of a dialysis unit experienced as a most important characteristic of a dialyzer, because the water balance of the patient is often difficult to handle.

The Gambro Lundia dialysers offer controlled ultrafiltration either by positive pressure in the blood compartments or, more conveniently and recommended by Gambro, by means of negative pressure in the dialysate compartments. Because of the low pressure drop in the blood system it is possible to dialyze with a very small ultrafiltration effect but on the other hand the potential ultrafiltration capability is very high making fast removal of excessive amounts of fluid possible.

Ultrafiltration *in vitro* is a laboratory testing of membrane permeability across the membrane related to isotonic solutions on both sides of the membrane. This is an important way of describing the membrane and it is useful especially when comparing different kinds of membranes and dialyzers. In practice this is compiled in the laboratory by recirculating a controlled volume. It is not possible to use this directly for predicting ultrafiltration in the clinical situation but the values are proportional to the *In vivo* situation.

When trying to correlate the ultrafiltration effect in a particular case to the graphs in figure II or published elsewhere there might be some discrepancies. There are many sources of error and variation. Special care should be taken on the points below:

1. The ultrafiltration effect depends on the osmolality of the dialysis fluid used. As an example: 1 g % sugar (gives an actual activity = about 30 mEq) added to the dialysis fluid reduces the ultrafiltration pressure with about 50 mm Hg when using the 17 u membrane dialyzer.

2. There is of course some variation in the electrolytic—water balance between different patients, which means that the tissues of the body have a variation in water content. In the practical situation this is very often experienced and explained as a patient is more or less easy to "ultrafiltrate".

3. The accuracy of the manometer used is of course very important, but a 15–25% misleading value is very common.

4. The location of the manometer differs in different kinds of equipment and a systematic misleading value moves the ultrafiltration graph. Compare the experiences with a coil machine adaptor and a low flow single pass system.

The removal of water from the blood stream—called "ultrafiltration"—is accomplished by control of the hydrostatic transmembrane pressure gradient between blood and dialysate but is of course dependent on the dialysate bath osmolality.

5. The misleading of the bed scale is another source of error: e.g. ± 300 g (which in other connections is considered to be a very good accuracy) in a situation of 3 kg ultrafiltration corresponds to a deviation of $\pm 10\%$.

6. The fluid input of the patient is usually difficult to establish; compare the variation in paragraph 8.

7. The output from the patient is in the same way difficult to establish.

8. Some variation in the dialyzer membrane ultrafiltration capacity is of course unavoidable. Gambro makes continuous control of the membrane quality and usually the variation is less than 10%.

Gambro Lundia Optima, is specially from the point of view of ultrafiltration, the safest and easiest dialyzer to use. Generally the above mentioned sources of error will statistically level each other out in the clinical situation. However, this explains how it is possible to obtain different data at different dialysis contra when using the Gambro Lundia dialyzers. If all errors are in one direction it is likely that a 20–40% difference will be noted.

Ultrafiltration Kg/h

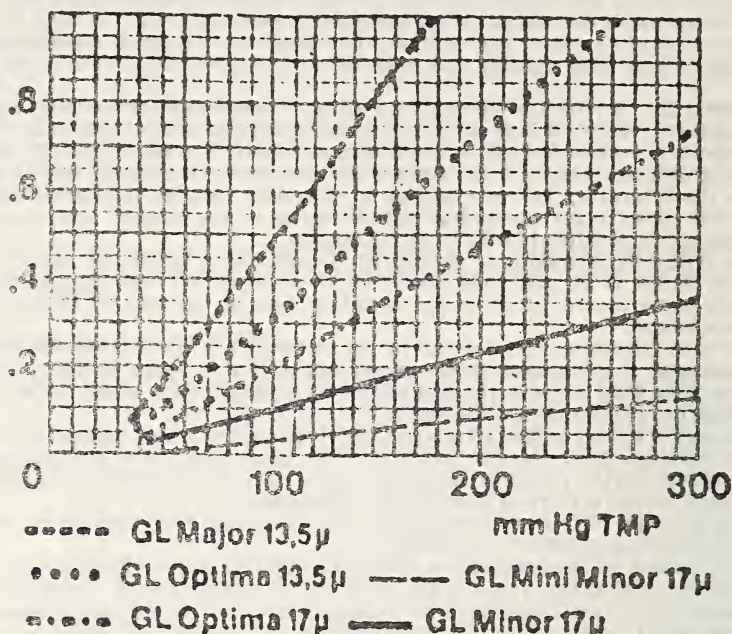


FIGURE II.—Shows the ultrafiltration related to the transmembrane pressure. On the graph is described the in vivo ultrafiltration with a dialysis fluid osmolality of 280 mm Osm/l. Fig. II relates to ultrafiltration effect to total transmembrane pressure. Total transmembrane pressure gradient means the difference between the graph is described the In vivo ultrafiltration with a dialysis fluid osmolality dialysis fluid system.

For example: Blood layers, +80 mm Hg.; dialysis fluid inlayers, -120 mm Hg.; and Pressure gradients is then 200 mm Hg.

Transmembrane pressure gradient:	<i>Ml per hour</i> ¹
300 mm Hg	1100
150 mm Hg	450
200 mm Hg	720
250 mm Hg	950
300 mm Hg	1100

¹ Gambro Lundia Optima 13.5 micron In vivo ultrafiltration.

NOTE.—For greater fluid removal, transmembrane pressure gradient may be increased beyond table values.

INSTRUCTIONS FOR USE OF THE GAMBRO DIALYSERS

The dialyser is delivered sterilized, non-pyrogenic and ready for use. Please control that both the inner- and outer package are in undamaged condition. In case of damage on the innerpackage which could jeopardize the sterility, the dialyser must not be used. The Gambro Lundia dialysers are intended for single use. The dialyser should be stored at a temperature between 50-75°F, 10-24°C and at a relative humidity of 50-60% to avoid possible deterioration of the membranes. Every dialyser is individually tested dry in both dialysate and blood compartments with a transmembrane pressure gradient exceeding 800 mm Hg centra when using the Gambro Lundia dialysers. If all errors are in one direction it is likely that a 20-40% difference will be noted.

Ultrafiltration Kg/h

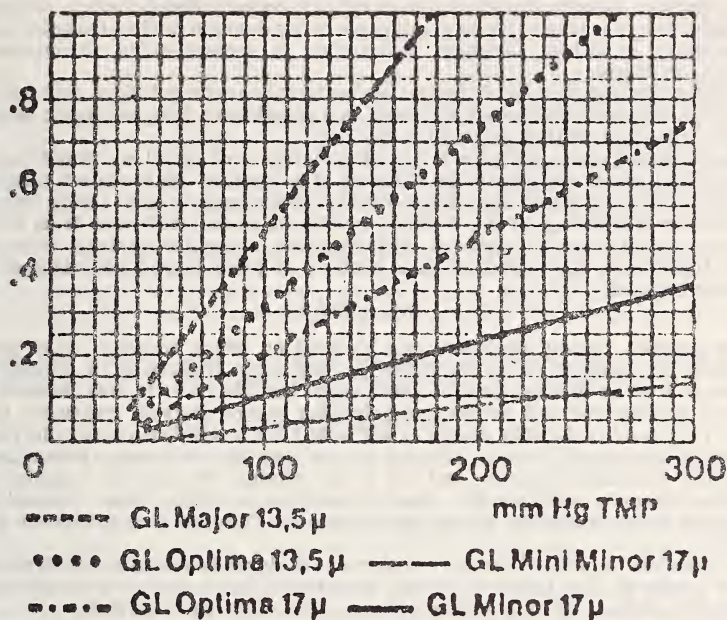


Fig II shows the ultrafiltration related to the transmembrane pressure. On the graph is described the in vivo ultrafiltration with a dialysis fluid osmolality of 280 mm Osm/l.

Fig II relates the ultrafiltration effect to total transmembrane pressure. Total transmembrane pressure gradient means the difference between the positive pressure in the blood layers and the negative pressure in the dialysis fluid system.

For example: Blood layers, +80 mm Hg; dialysis fluid layers, -120 mm Hg; and pressure gradient is then, 200 mm Hg.

Transmembrane pressure gradient:

Milliliters
per hour

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The construction is covered by domestic and foreign patents and patent applications.

CAUTION

The Gambro Lundia dialyzers are carefully manufactured, tested, packed and sterilized. No guarantee can be given concerning damage during transport or due to improper handling. Constant monitoring is recommended throughout the dialysis procedure.

Please study the Gambro information material carefully before using the dialyser. The dialyser is delivered sterilized in a plastic bag. Proper aseptic technique must be employed while handling the dialyser.

The Gambro Lundia dialyser is a sophisticated mechanical construction and it is important when unpacking the dialyser it is handled with utmost caution.

No type of agent, sterilizing, disinfectant or other may be used inside or outside the dialyser without carefully testing or without recommendation from Gambro.

Agents containing halogenated hydrocarbons (perchloroethylene, chloroform, iodine tinctures), denatured ethanol, acetone or phenols and derivatives of these must not be used.

INDICATIONS

The Gambro Lundia dialysers can be used on every occasion when dialysis treatment is required. It is indicated in long term treatment in chronic renal failure as well as in situations of acute renal insufficiency. It may be used in all cases of endogenous and exogenous poisoning where dialysis treatment is indicated. The Gambro Lundia design is suitable both in clinical center dialysis and in home dialysis and it can be adopted to any type of monitoring system. Because of the low internal resistance and low blood volume, the Gambro Lundia dialysers are extremely suitable for running doubles or triples thus increasing the membrane area according to the hypothesis on "middle size molecular uremic toxins".

The Gambro Lundia Minor is a smaller size dialyser intended for dialysis of low weight patients. The Gambro Lundia Major is a large surface area dialyser intended for dialysis of high weight patients and short time dialysis.

DIALYSING WITH THE GAMBRO LUNDIA DIALYSERS

Preparation

1. Place the dialyser in the holder in a vertical position and connect the bloodlines. Make sure that the connectors on the bloodtubings are properly fastened. The dialyser is completely symmetrical, but for ease of use, consider the labeled end (Gambro Lundia) the arterial and have it positioned at the top. Bloodline connectors must be kept sterile! The smaller diameter connectors lead to the blood channels.

2. Connect arterial line perfusion cannula to heparinized saline and close off the tube with a clamp. The free end of the venous tube, which is provided with a drainage hook, is placed in an empty bottle. Clamp the line!

3. Connect the outlets to the pressure gauges for the respective manometers.

Steps 1-3 should be carried out in sequence not to jeopardize sterility.

4. Connect dialysis fluid lines. Make sure that the connectors on the dialysis fluid lines are properly fastened. Inlet line connects to the venous end and the outlet line to the arterial end. Activate the dialysis fluid system with a negative pressure of 50-100 mm Hg.

Some machines cannot withdraw the air from the dialyser and in these cases it will be necessary to prime the dialysate channel. This can be done either by filling the dialyser with saline or simply by connecting the dialyser to the machine and allowing the dialyser to fill from the headertank in the machine.

Caution—Please note that the connectors on the bloodtubings and dialysate tubings are properly fastened to the dialyser and that the tubings are not twisted.

Priming

Before the patient is connected to the blood system, it must be primed with physiological solution. Approximately 400-500 cc is necessary to remove all air from lines and dialyser. The arterial line has a special segment for the bloodpump. Insert this section of the tube into the pump housing. If connection to the patient for some reason is delayed, once the dialyser has been flushed, it is recommended that some solution is added before connection, so that some positive pressure remains in the blood system (20-100 mm Hg) upon connection. The dialysis fluid system should have some negative pressure (minus 50-100 mm Hg).

5. Turn the dialyser upside down so that the arterial inlet line to the dialyser is at the bottom. It is extremely important to keep the dialyser in this position

throughout priming. Priming must be from bottom to top to ensure that all air is removed from the dialyser.

6. Remove the clamps from the arterial and venous lines and start the blood-pump at a high rate (300–400 ml/min). pumping the saline through the dialyser.

7. When the dialyser is filled, the solution comes out through the drainage hook. Clamp the venous line several times to raise the pressure to 200 mm Hg. Any remaining air is accordingly flushed out. To facilitate this procedure, set the venous pressure meter's maximum indicator at 200 mm Hg and close off the venous with a clamp. The bloodpump increases the pressure and will stop when the manometer pointer reaches the meter indicator. The function of the manometer and bloodpump is thereby checked and this procedure also ensures that there is no leakage in the bloodsystem. The pressure must be maintained for a few seconds.

8. Fill the bubbletrap of the venous line. Not more than one cm (0.5 inch) of air may remain in the trap.

9. When the dialyzer is primed, clamp the venous line. The blood pump is turned off, when pressure in the blood system is about 100 mm Hg. Clamp the arterial line.

10. Turn the dialyser back to original position so that the arterial side is at the top. The dialyser is now ready to be connected to the patient.

TO FINISH DIALYSIS

1. Clamp the arterial line and remove it from the patient. Connect this line to a bottle of saline.

2. Reduce any negative pressure in the dialysate, unclamp the arterial line and start the infusion of the saline. Infuse approximately 300 cc of saline into the blood compartments. Increase the pressure in the bloodsystem by momentarily clamping the venous line a few times.

Caution—Beware of air embolism risk, if air rinsing procedure is used.

3. When the dialyser is empty of blood, clamp the lines, disconnect the patient and dispose of the dialyser and lines.

CONTRAINDICATIONS

There is no absolute contra-indication to dialysis. However, critical cases of bleeding tendencies must be carefully judged by the doctor. Avoid giving intramuscular and subcutaneous injections during or immediately after dialysis treatment. When an acute hemorrhage, arising during dialysis, cannot be corrected (hematomas or melaena), treatment should be discontinued. Protamine solution can be infused in order to neutralize the heparin effect. Patients with a bleeding tendency should be heparinized with an infusion machine to keep coagulation time as brief as possible. Regional heparinization can also be considered. Always try to assess the magnitude of blood losses so that they can be compensated.

GUARANTEE

(A) The manufacturer guarantees that the Gambro Lundia dialyser ("the dialyser") has been carefully manufactured, tested, packaged and sterilised and that the dialyser has been individually tested in dialysate as well as in blood compartments with a pressure gradient exceeding 800 m.m. Hg and that the dialyser will be replaced if proved to be defective by reason only of faulty design, workmanship or materials in manufacture or packaging and the manufacturers are notified of the defects within 12 months of the date of delivery provided as follows:

(i) That the dialyser is only used in accordance with these instructions.

(ii) That the dialyser is in no circumstances reused.

(iii) That the manufacturer is notified of the defect in writing quoting the manufacturing number within 14 days of the date the defects become apparent.

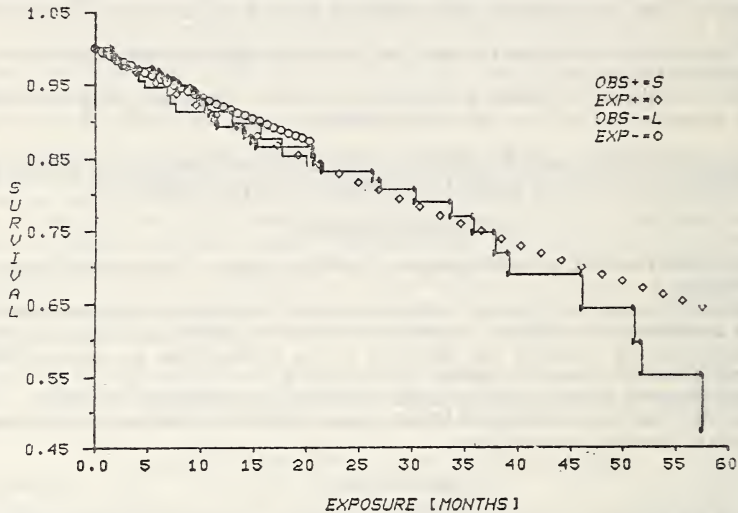
(B) Except in so far as the Supply of Goods (implied Terms) Act 1973 provides to the contrary the undertaking contained in paragraph (A) above is given in lieu of and to the exclusion of all conditions, warranties and representations whether express or implied by statute or otherwise as to the quality of the dialyser or its fitness for any particular purpose or otherwise and the manufacturers shall have no liability in respect of the dialyser save as provided in paragraph (A) above.

(C) The manufacturers shall not be responsible for any injury damage or loss caused directly or indirectly by the use of the dialyser and whether as a result of any defect therein or otherwise and the manufacturers shall be indemnified from any claim arising from such injury damage or loss.

Figure 1

COMPARATIVE SURVIVAL CURVES FOR UREMIA III-U

(Letter to J. P. Merrill, M.D. 10/6/77)



Senator TALMADGE. There being no objection, I will ask Dr. Blagg to provide for the record a written response to the testimony of Dr. Lowrie.

[The following was subsequently supplied for the record:]

OCTOBER 26, 1977.

Senator HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee,
Russell Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: Thank you for giving me the opportunity to comment upon the testimony of Dr. Edmund Lowrie presented at last week's hearing on HR-8423 held by your subcommittee. This testimony draws inappropriate and erroneous conclusions from data presented previously by the Northwest Kidney Center, Seattle. His conclusions are at variance with the general views of most nephrologists in this country and elsewhere.

I would like to comment on the major issues raised by Dr. Lowrie, and to have these comments entered into the record.

THE COST OF HOME DIALYSIS

Dr. Lowrie claims that the cost of home dialysis is almost equivalent to the cost of outpatient dialysis in a facility. This issue was raised previously at the House hearings, following which I presented a detailed analysis of Seattle costs recast in the same fashion as the data from the Peter Bent Brigham Hospital for comparison. If, as I believe appropriate, the cost of training and initial set-up at home is included in the first year cost, then the cost of home dialysis in the second and subsequent years in our program is \$11,566, or using Dr. Lowrie's figures to eliminate equipment reuse, \$15,436. This is significantly less than the \$23,400 per year for outpatient dialysis.

This does not include helper costs. Dr. Lowrie believes these should be included in the comparison, because HR-8423 includes a provision for the use of helpers where necessary. However, the Bill places an upper limit on reimbursement for home dialysis of 70 percent of the figure for outpatient dialysis, certainly not enough margin to pay for full helper support for most patients. In any case, most patients are able to perform self-care dialysis themselves or with family assistance.

The G.A.O. study, the N.I.H. study, Bureau of Health Insurance data, and other cost data all confirm that the cost of home dialysis is less than the cost of outpatient dialysis. Whether this cost differential is only of the order of \$1,500 a year, using the Boston figures, or greater than this as in most other estimates, passage of HR-8423 as presently written will result in a cost saving of approximately \$7,000 per patient year, because of the 70 percent target rate for home dialysis.

The important issue in considering HR-8423 is not just the magnitude of the cost saving, but rather the quality of care provided to patients by home dialysis. This has been amply documented in the medical literature, and was discussed in detail by Dr. Scribner at the House hearings.

Attachment 1 contains further comments on some of Dr. Lowrie's remarks on cost.

RESULTS OF THERAPY—STATISTICAL CONSIDERATIONS

Much was made in Dr. Lowrie's testimony of my previous statement that our patient survival on dialysis at 3 years is 58 percent. Dr. Lowrie states that the "only obvious reason for this inferior patient survival in Seattle is the indiscriminate use of home dialysis therapy" without quoting by explanation in the letter to Mr. Rostenkowski of May 11, 1977, that this figure was for all dialysis patients, not just home dialysis, and included diabetics and also long-term incenter patients who are generally elderly or who have serious complications. Twenty percent of our patients are diabetics who have a 3 year survival on dialysis of 27 percent, 11 percent of our patients are over the age of 65 with a 3 year survival of 33 percent, and 14 percent are aged between 55 and 65 with a 3 year survival of 55 percent. The 3 year survival of all non-diabetic patients in our program is 84 percent in those aged 15 to 24, 82 percent age 25 to 35, 76 percent age 1 to 15, 74 percent age 35 to 45, and 65 percent age 45 to 55. These figures are based on all the 930 patients treated through July 1977. The longest survivor is dialysis is now in his 16th year, of which more than 11 years have been on home dialysis, and we now have a number of patients who have survived more than 10 years on home dialysis.

When we look at patient survival on home dialysis and exclude the center dialysis patients, the 3 year survival in our program is 74 percent including diabetics; if we exclude diabetics, the 3 year survival in patients aged 55 or less is 81 percent on home dialysis, and for patients over the age of 55 is 55 percent. These results are comparable to those of other programs.

It is significant that Dr. Lowrie does not comment on the population base from which the Brigham figures are drawn, except to say that he does include older patients and patients with diabetes. I contend that in order to draw the conclusion made by Dr. Lowrie, he must show that the patient population treated at Peter Bent Brigham Hospital is representative of the general population of the patients in Massachusetts, and comparable with our patient population, which is all patients from Western Washington state with the exception of V.A. patients, and that the age distribution and percentage of diabetic patients is similar.

Dr. Lowrie also refers to 68 percent survival from the National Dialysis Registry in comparison with our 58 percent, but omits to point out that the National Registry data contained only 7.2 percent of patients who were diabetics, and that a study by the National Dialysis Registry showed no difference in survival between home dialysis and incenter dialysis. The other papers referred to by Dr. Lowrie (Dr. Lowrie's references 1, 8 & 9) also do not refer to comparable patient populations.

Dr. Lowrie, who has considerable statistical experience, must be well aware that in comparing statistics in this fashion, it is a first essential to demonstrate that the patient populations to be compared are in fact comparable. I submit that this is not the case, and that the conclusion he has drawn, that there is a poorer survival for patients treated by home dialysis, is a false conclusion and unacceptable statistically.

I would be the first to agree that the data in the literature which shows a higher survival rate for patients treated by home dialysis, is biased because of patient selection. However, I have never claimed that home dialysis has a better survival than outpatient dialysis, and in fact if it were possible to perform a truly controlled trial of the two forms of therapy, in similar patients, the results would likely be approximately equal. What is at issue here, rather, is the question of the quality of life for the patient treated by home dialysis. This has been discussed at length by Dr. Scribner in his testimony before the House, and has been extensively documented in the literature. It is significant that even the opponents of HR-8423 and home dialysis have not criticized the benefits of home dialysis for those patients able to perform this successfully.

HOME HELPERS

In Dr. Lowrie's comments on helpers, he refers to nurses. As Director of the center which was the first to develop an organized program for use of home dialysis helpers. I would point out that we do not use either nurses or dialysis technicians as home helpers. We use any suitable willing lay person who we believe can be trained, who is acceptable to the patient. If it is possible to train a patient or a family member to perform safe home dialysis, it is certainly possible to train other lay people to carry this out. As has been shown by ourselves and by Roberts (Attachment 2), intelligence and social background are not important in determining success with home dialysis. To use nurses as home dialysis helpers is a waste of highly trained health care personnel.

Dr. Lowrie referred in his oral testimony to an article in the Journal of the American Association of Nephrology Nurses and Technicians by Marcia Clark, R.N., M.S., our Renal Coordinator. This article (Attachment 3), discusses our experience with home dialysis helpers. Dr. Lowrie, by innuendo, implied, that one cause of what he believes to be the inferior survival of our home dialysis patients was the use of helpers. However, this article demonstrates that our helper program is carefully organized, and that regular followup visits enable us to maintain surveillance of the helper program just as we maintain surveillance of all patients on home dialysis. At present, numbers are too small to estimate statistically the survival of patients with helpers as compared with other patients, but we have no reason to believe there is a difference.

CONCLUSION

I reject Dr. Lowrie's hypothesis that the overall patient survival rate in our program is lower than that of other selected patient populations such as the Peter Bent Brigham Hospital because of our widespread use of home dialysis. I contend that our survival results are perfectly compatible with the patient population treated, and, in fact, that the survival of our patients when subdivided by age and diagnosis is comparable or better than survival reported by the National Dialysis Registry (Attachment 4).

I disagree with Dr. Lowrie's statement that the cost of home dialysis approaches that of outpatient dialysis.

I raise the question as to why the only physicians testifying that the cost of home dialysis is almost as high as that of incenter dialysis and that home dialysis has an inferior survival rate have been representatives of National Medical Care—the largest company owning outpatient dialysis units in the United States, and physicians from the Peter Bent Brigham Hospital in Boston and from Louisiana. Both groups of physicians are on the staff of hospitals which refer the majority of their dialysis patients to large proprietary dialysis units for long-term outpatient therapy. The patient may well continue to be cared for by the same physician in the proprietary dialysis unit. Dr. Lowrie, in the introduction to his statement, describes his affiliation with Harvard Medical School and the Massachusetts Institute of Technology, but omits to point out that he is also associated with the Babcock Kidney Center in Boston, a large private facility owned by National Medical Care. This relationship puts into serious question the objectivity of his comments.

I remain convinced that it is important that HR-8423 be passed with all possible dispatch in order to right the problems of the present ESRD Medicare program. That these are real problems is demonstrated by the fact that Senator Russell Long introduced S-1492 as far back as 1974 to address many of the same

problems as does the present Bill. The Renal Physicians Association and the National Kidney Foundation, which between them represent the vast majority of physicians caring for ESRD patients in the United States, including many physicians associated with proprietary dialysis units, both wholeheartedly endorse the Bill, as does the major patient organization—the National Association of Patients on Hemodialysis and Transplantation. I cannot believe this would be the case if there was serious concern on the part of an appreciable number of physicians that home dialysis is, in fact, a less safe form of therapy.

In no way does HR-8423 in its present form force patients to go home, since the mandatory quotas have been removed. However, I do believe strongly that the national goal that a majority of future patients should be treated by self-care dialysis at home or in a center, or actively considered for transplantation should be retained. If this is not the case, it is possible that the lower physician reimbursement for home dialysis may act as a deterrent to some physicians, preventing them from sending their patients home or having them transplanted and so negating some of the hoped for benefits of the removal of disincentives to patients in HR-8423.

I contend that Dr. Lowrie's arguments against home dialysis are specious, and that he has presented no information that should in any way affect early passage of HR-8423.

I would be happy to discuss these or any other related issues further with you or your staff at any time, either by mail or in person. Thank you for your consideration of these comments.

Sincerely yours,

CHRISTOPHER R. BLAGG, M.D.,
Director.

Attachments.

ATTACHMENT 1—COMPARISON OF THE COST OF HOME DIALYSIS IN BOSTON AND IN SEATTLE

I am in general agreement with Dr. Lowrie's criticism that past estimates of the cost of home dialysis in the literature have not necessarily included all relevant items, and often have been estimates made by physicians. However, the Northwest Kidney Center data presented in my letter to Mr. Rostenkowski of May 11, 1977 were developed by our accounting staff, and our books are open to inspection at any time.

It is instructive to reanalyze Dr. Lowrie's estimates of our costs taken from Table 1 of his testimony. In our program, the extra cost of the initial training and establishment of the patient in the home over the cost of maintaining the patient on outpatient dialysis is \$4,086. The average patient in our program is trained and at home within two to four months of starting dialysis. Taking the longer four month time, this represents a cost for outpatient dialysis during this first year, based on our data, and including backup dialyses but excluding a helper, is $(\$12,928 \div 52) \times 36 = \$8,007.30$, making a total first year cost of \$19,293.30. If instead, we use Dr. Lowrie's calculations of our data in order to exclude reuse, this figure becomes \$22,473.40—roughly comparable to the one year outpatient dialysis cost of \$23,400. In following years the annual cost is \$11,566, or, using Dr. Lowrie's figure with no reuse, \$15,436—an appreciable cost saving.

The cost of initial plumbing and electrical modifications in our data is taken from actual patient bills.

Our three week training program is reimbursed at \$295 per dialysis, and we do in fact have an exception to charge at a level higher than the usual screen rate of \$190 per training dialysis. This is because we train patients 5 days weekly, yet Medicare can only reimburse for actual dialysis sessions. As it is inconvenient for patients to stick their fistulas five days weekly, we only perform 3 dialyses weekly and perform other training functions on the remaining two days. Our average training cost, exclusive of physician fees, is $9 \times \$295 = \$2,655$. This compares with the Boston 8 week training cost of \$4,940.

I do not wish to comment further on the reuse issue, except to say that we have used reuse successfully, and without serious problems, in our home dialysis program since we first introduced this technique in Seattle in 1967. However, I would welcome a study by the FDA or other responsible body to settle the role of reuse once and for all.

Our figures for equipment rental are lower than Boston figures, not because of the use of older or depreciated machines, but because the Northwest Kidney Center itself purchases the machines, and is able to lease them to the patient at a lower rate than could a manufacturer. This is because it is easier for us to refurbish and recycle machines when a patient is transplanted or dies.

Dr. Lowrie believes that helper costs should be included in the comparison of cost because passage of HR-8423 would encourage more widespread use of helpers. However, as the bill places an upper limit on home dialysis reimbursement of 70 percent of outpatient dialysis reimbursement, this certainly will not give enough margin to provide full helper support for a given majority of patients. In our program at present only 10 percent of patients have paid helpers, and only 6 percent of patients have so-called full helpers at an extra cost of approximately \$4,992 per year. If home dialysis is reimbursed at the rate of 70 percent of \$23,400, then the maximum reimbursement per year, exclusive of physician fee, will be only approximately \$16,380. Even with reuse on the Seattle pattern, this will not be enough to pay for a full helper for the majority of patients. However, whenever possible the patient should perform his or her own dialysis with the assistance of a family member, and there is not intent to use helpers indiscriminately.

ATTACHMENT 3—EXPERIENCE WITH PAID DIALYSIS HELPERS

(By Marcia Clark, R.N., M.S.)

Since 1967, all patients of the Northwest Kidney Center have been treated by transplantation or home dialysis, both hemo and peritoneal. Although some patients using cannulas for hemodialysis and some patients being treated peritoneally can safely dialyze alone at home, it is preferable that a second person be in attendance. This is essential for dialysis using a blood pump.

FIGURE 1—LEARNER STATUS

1. Patient (+one, offering minimal assistance) : Patient primary learner.
2. Patient+one : Both learn as a team.
3. One+patient : Patient secondary learner.
4. One+patient : Patient offers no assistance.

Whenever possible, the patient is considered the primary learner in the training setting. If a second person is involved, he offers only minimal assistance, essentially performing as the "third hand." In other instances the patient and a second person, generally the spouse, often train as a team where both learn the materials equally as well. In still other situations the patient is definitely the secondary learner performing then as the assistant. A fourth category consists of patients who essentially are not able to assist in carrying out any significant portion of the dialysis procedure due to medical, psychological, or intellectual handicaps. It is these last two learner categories where assistance is mandatory that attention is directed.

Even before the need is known, discussion regarding dialysis helpers is begun during the social worker's initial intake interview, prior to formal acceptance by the Kidney Center so that the patient and his family can begin thinking about preparation for these roles. Information gathered at this time will also assist the staff in their decisions regarding type of treatment and blood access.

After a dialysis patient is medically stable and prior to entering home training, testing is performed by a psychologist to determine learning capabilities.[1] From his results he is reasonably able to screen those patients who he feels "could not master home dialysis safely." In other words, the learning capabilities of the individual patient are generally identified before beginning home training. Testing may be extended to include others who might be participating in the learning process as needed.

If the patient requires assistance, it is generally provided by a family member or friend for which the patient makes his own arrangements on a non-pay basis. In the event these resources are not available to him, he or the Kidney Center attempts to find an individual to work as a helper in a pay status.

FIGURE 2.—REPORT OF PSYCHOLOGICAL EVALUATION

[Mrs. B., age 54]

WAIS:		Wechsler memory scale—Continued	
Information (scaled scores) _	6.0	Digit span_____	8.0
Similarities _____	4.0	Associate learning_____	9.5
Digit span_____	6.0	Total raw score_____	54.5
Vocabulary _____	8.0	Age corrected score_____	98.5
Block designs_____	10.0	MQ_____	100.0
Verbal I.Q._____	78.0	Graham Kendall MFD error	
Wechsler memory scale:		score_____	7.0
Information _____	5.0	Raven P.M. (percentile 25) total_	18.0
Orientation _____	5.0	Wide range achievement test	
Mental control_____	7.0	(grade level) _____	7.5
Logical memory_____	6.0		

INTERPRETATIONS

Mrs. B. is a woman of rather limited intellectual prowess. Her memory for simple materials is about average for her age. She will have trouble with both the mechanical and verbal aspects of training. I feel that she will have considerable trouble learning home dialysis and will have problems maintaining her treatment without assistance.

RECOMMENDATIONS

1. She will require extra practice on much of the material.
2. Another person should be trained to assist and supervise her as much as possible.

FIGURE 3.—CENTER RESPONSIBILITIES

1. Assist in locating and screening candidates;
 2. Assure adequate training; and
 3. Fund as necessary
- The Center provides training for the helper for the type of dialysis required, and attempts to seek further placement for him in the event his patient no longer requires his service.

After having determined by appropriate testing during training that the helper has clinical and technical qualification to perform the tasks for which he was trained, the Center assumes no responsibility for his subsequent performance.

The helper fee is determined by the patient and his funding sources. For the patient with funding sources independent of the Kidney Center, the fee and its starting date will be determined solely by that individual and the helper, although the Center may be requested by the patient to recommend an appropriate amount. The Kidney Center establishes the fee for those patients for whom it manages partial or total funding. The fee in these situations begins after training when the patient and helper have begun treatment in the home.

FIGURE 4.—CONSIDERATIONS FOR REIMBURSEMENT

1. Level of dialysis experience.
2. Service required of helper:
 - (a) Type and complexity of tasks to be performed;
 - (b) Frequency and duration of treatment; and
 - (c) Medical stability of patient.

Considerations for fee include the level of dialysis experience, the service required of the helper with his particular patient; that is the type and complexity of tasks to be performed, the frequency and duration of treatment and the medical stability of the patient.

In the case of Center funded patients, the helper records his hours, the patient signs the time record and presents it to his funding sources for reimbursement.

The helper is not in the employ of and is not paid directly by the Kidney Center for three primary reasons.

When the helper is directly responsible to the patient he is more likely to be responsive to the patient's needs. It further prevents the Center from being drawn into and potentially compounding any interpersonal conflicts that may arise. The Center also wishes to avoid responsibility for an employee which the helper would be if he were paid directly by the Center since close supervision in this type of arrangement is near impossible.

The patient, or Center if requested, notifies his physician about his helper including some background information with regard to education, experience, and other responsibilities. The physician is free to contact the helper if necessary. In certain instances it is desirable for the helper to accompany the patient on routine physician visits in order to receive appropriate instructions from the physician regarding any changes in the dialysis regimen.

A home visit is made by the training staff six to eight weeks after the patient and helper have begun dialysis in the home setting for purpose of performance evaluation. A full report is then prepared which includes a questionnaire, scoring data related to selected parts of the dialysis procedure and a narrative summary. Further follow-up visits are scheduled on the basis of need following the routine for all home dialysis patients.

Termination of the helper is at the discretion of the patient for whom he works. However, when the patient is reimbursed for helper fees by the Center, the Center may elect to terminate funding for fees in the event it is felt the helper's performance is unsatisfactory.

Certain patients have found, trained and paid their own helpers. In other situations, past employees of the Center have assisted patients and been paid directly by them. Since there has been little involvement by the Center with this group these figures are not included here.

FIGURE 5

Helpers trained by Kidney Center -----	63
Patients assisted by trained helpers -----	67
Patient months with helpers -----	642

In the past 5½ years, 63 helpers have been trained by the Kidney Center, 7 for peritoneal, 53 for hemo and 3 for both modes of treatment. Collectively they have assisted 67 patients for 642 patient months.

The helpers have been located through newspaper advertisements, through the local colleges and universities, through acquaintances of the patients, through public agencies and through word of mouth. The number of responses at times has been overwhelming. Treatment generally takes place three times per week for a period of 4-13 hours each, the longer treatments being for peritoneal patients. The patient is generally medically stable when discharged to home. Equipment for home dialysis includes safe monitoring devices to permit overnight dialysis which is strongly recommended. This regimen then becomes most enticing to the person with a daytime schedule be it work, school, or family responsibilities, who desires without interruption to those, a means of gainful employment.

Screening of the candidate is done by the patient with assistance from the Kidney Center as required. The Center informs the patient what he can realistically expect from the helper in terms of commitment, responsibilities and potential problems.

The helper with his patient, goes through the same training program as other patients. The average training time for patients at the Northwest Kidney Center for both hemo and peritoneal dialysis is 2-3 weeks. The helpers are generally able to complete training in this same period of time.

With regard to the legal implications, the Center is responsible for the acts of its employees. Therefore, caution is taken to assure that all parties clearly understand that the helper is an independent contractor who works under the direction of the patient. The Center provides the patient with sufficient information to impress the helper with his potential responsibilities, thus encouraging an intelligent decision on the part of the helper regarding acceptance of the role. The Center assures the adequacy of training and provides the same consultation

services and support regarding dialysis treatment as it does for any of its patients and non-paid helpers.

The courts have held that one is liable for the reasonably foreseeable consequences of his act or failure to act in any place where he has duties. Therefore, the duty of the Center is carefully limited to using reasonable care in the process of selection of the applicant and further in providing training satisfactory for safe and proper dialysis of the patient. Negligence in these areas could expose the Center to liability.

FIGURE 6.—ADVANTAGES

1. Early return to home.
2. Less expensive than in-center dialysis.

DISADVANTAGES

1. Time spent resolving interpersonal problems.

In general the program has proved to be quite successful. It has allowed an early return to home for patients who might have been detained in the Center for lack of a required dialysis assistant. The helpers have assisted the patients significantly in adhering to their medical regimen thus contributing to their rehabilitation. The helpers' interest has remained high as evidenced by their desire to assist another patient immediately if their no longer requires their service. There have been few back-up dialyses due to lack of responsibility on the part of the helpers. Dialysis at home with a helper has proven to be less costly than in-Center dialysis for the same period of time.

FIGURE 7.—ANNUAL MAINTENANCE DIALYSIS COSTS

Center dialysis (\$138/dialysis, excludes physician)	\$20, 528
Home dialysis—without helper (includes lease of equipment, excludes training)	7, 500
Home dialysis—with helper (includes lease of equipment, excludes training)	12, 500

Probably the most significant problem and one which occurred with greater frequency earlier in the program has been in the area of interpersonal relations between the helper and the patient. Although time consuming, these have generally been readily resolved. This seems to be lessening as we most strongly encourage the patient to find his own helper. When the Center assists in locating a helper, an attempt is made to offer a choice and encourage several interviews between patient and several candidates before a decision is made.

Although there have been requests by a given helper to assist more than two patients at a time, this has been discouraged since the amount of time involved decreases flexibility in the event dialysis schedules need to be modified.

It was hoped that with a pool of helpers, relief could be offered for other helpers be they in a pay or non-pay status. Caution is exercised here since thorough training must be accomplished for each type of equipment and mode of blood access used. It is further recognized that the helper has become familiar only with the dialysis patterns of his own individual patient, but not of every patient.

This program has been especially helpful for the older patient with decreased mental acuity who may have no suitable helper, frequently has difficulty with travel to the Center, and probably manages better in his own home setting. It becomes more attractive as this type of patient comes from areas increasingly remote from the Center. It has proved highly successful and is recommended as an important and economical alternative to in-Center dialysis for patients lacking necessary social support.

In closing, it should be mentioned that the helper program was not formally conceived and planned as it now exists. Like so many other things it began as a solution for an existing need, namely, an elderly uremic patient with a blind diabetic, but financially secure husband who found, had trained, and reimbursed a helper. Likewise a second blind diabetic, wealthy patient found and requested training for his helper. With success in these instances and with an ever increasing need, guidelines in the training, use, and reimbursement of helpers came into being as a helper program somewhat fortuitously developed.

REFERENCE

1. Snow, Willard, and Clark, Marcia, "Understanding Patient Learning and Performance Capabilities for Home Dialysis Training," *J. AANNT*, Vol. 3, 1976 (20-24).

Senator TALMADGE. For the record, I also want to state that I know of no member of this committee or the Congress who wants to insist on home dialysis.

[The following letter was subsequently received for the record:]

PETER BENT BRIGHAM HOSPITAL,
Boston, Mass., October 28, 1977.

Re H.R. 8423

Senator HERMAN TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee, Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: Enclosed please find a letter that I sent to Dr. Blagg on October 28, 1977.

I would like to request that this letter be incorporated into the testimony on H.R. 8423.

Very sincerely yours,

EDMUND G. LOWRIE, M.D.,
Director, Hemodialysis.

PETER BENT BRIGHAM HOSPITAL,
Boston, Mass., November 8, 1977.

CHRISTOPHER R. BLAGG, M.D.,
*Northwest Kidney Center,
Seattle, Wash.*

DEAR CHRIS: After the hearings on HR 8423 last Friday, you told me that the reason for your relatively poor survival was the inclusion of diabetic patients. You further said that you would organize your data during the week-end and forward it to me. Inasmuch as I have not heard from you, and Senator Talmadge asked if we had communicated on these matters, I have elected to take the initiative and write directly to you.

We have considered further, during the past week, the matter of survival and we are unable to find any cause for your high mortality, other than home dialysis, per se. The claim that you included diabetics is simply no explanation. Most of us treat diabetics and the elderly and include them in our survival data. The National Dialysis Registry data, cited at the hearings, included both diabetics and the elderly. Excluding such patients from your survival data clearly renders them not comparable and highly misleading.

As you know, much of our data was collected under contract to the AK-CUP of the NIAMDD. It has been reported in the proceedings of last year's Contractors Conference and I have reviewed our diabetic survival. As you know, all physicians have reported survival rates for diabetic patients which are inferior to those for nondiabetic individuals. Our cumulative diabetic survival at one, two and three years was 78, 68 and 60%, respectively. The point is that our survival rate in diabetic patients at three years was higher than that reported by you for all of your patients, 80% of whom are on home dialysis.

Now that these issues have been raised, Chris, I am sure you agree that they must be resolved on their own merits by persons of good faith, without regard for who is ultimately proven right or wrong. As I mentioned in my letter to you last Friday, a health care system which will be less flexible than before is taking shape. Patients as well as physicians will have to live with the results for some time.

Very sincerely yours,

EDMUND G. LOWRIE, M.D.

Senator TALMADGE. The next witness is Harold O. Buzzell, president, Health Industry Manufacturers Association.

STATEMENT OF HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, ACCOMPANIED BY ROBERT M. COLLINS, CHAIRMAN OF THE BOARD AND PRESIDENT, COBE LABORATORIES, INC.

Mr. BUZZELL. Mr. Chairman, I am Harold O. Buzzell, president of the Health Industry Manufacturers Association and with me today, is Robert Collins, the president of Cobe Laboratories.

Our association represents 250 manufacturers of medical products, including the dialysis products being discussed today. The manufacturers have supported the program with the technology that has enabled the program to be effective and we also have a direct interest in the reimbursement aspects of the program.

The basic principles of H.R. 8423 are sound. However, some clarification and improvement is needed. Our basic concern with H.R. 8423 is that it does not emphasize the need to assure the best interests of the patients regardless of the mode of treatment.

Clearly, the bill will encourage better utilization of home dialysis and the manufacturers are prepared to support this concept. However, a limited number of provisions with respect to home treatment could reduce the effectiveness of manufacturers in supporting the home patients.

Our comments are addressed to clarifications in this area.

Second, we hope that the subcommittee will consider the perspective of manufacturers when considering reimbursement procedures and policies. Our suggestions will, we believe, substantially aid in extending the purposes of the legislation.

Concerning home dialysis support services and equipment, we support the bill's concept of providing comprehensive payment. This provision should eliminate a number of administrative obstacles for both the patient and the manufacturer.

According to H.R. 8423, the dialysis facility will assume full responsibility for directly obtaining or arranging for the provision of dialysis equipment, maintenance, and repair services. However, the bill does not adequately recognize that manufacturers are best suited to maintain and repair their own equipment with experienced personnel and parts or assemblies tested and approved for installation.

In our view, the bill could be improved by suitable language so that the manufacturer of the equipment would ordinarily be afforded the first opportunity on maintenance and repair services sought by a facility.

Further, repair and maintenance of equipment should include preventive maintenance. This will afford immeasurable savings through reductions in the cost of incidental repairs.

In addition, we understand that the Secretary would be authorized to provide for the acquisition and installation of supportive equipment. This provision, also, we think needs clarification. Manufacturers design their products as integrated systems and do not understand why additional supportive equipment would be needed for prolonging useful life of the equipment.

Unless the intent of this provision is clarified, we are concerned that the Secretary could make unwise decisions with respect to the supportive equipment.

The manufacturers of dialysis equipment are in the best position to evaluate the useful life of their products and we would hope for consultation with the Secretary before any criteria for supportive equipment might be developed.

I next would like to turn to reconditioning of dialysis equipment. A provision in the bill indicates that approved providers of service and renal dialysis facilities are entitled to reimbursement for reconditioning for subsequent use of dialysis equipment and the supportive equipment, including blood pumps, bubble detectors, heparin pumps, and other alarm systems.

The reconditioning of dialysis equipment by persons other than the manufacturer, as apparently authorized by this provision, raises two serious questions. First, the reconditioning procedure, if performed incorrectly or inadequately, could jeopardize both the safety and effectiveness of the product. Second, the original manufacturer of reconditioned equipment might be held accountable under certain product liability doctrines, for the safety of the product, even though modifications or changes may have been completed by other parties.

We are not suggesting that the reconditioning of dialysis equipment should be abandoned. Rather, the manufacturers believe most strongly that reconditioning of equipment should only be performed by trained personnel of the original manufacturer, either in the field, or at the original manufacturer's facility.

Inclusion of this recommendation in the bill will assure that the performance of reconditioned equipment will be compatible with advancing technology and patient safety.

Next, the trial use of dialysis equipment. The bill authorizes pilot projects for financial assistance in the purchase of new or used equipment for use in the home. Provision is also made for a trial period to assure successful adaptation to home dialysis before the actual purchase of the equipment.

The equipment manufacturers have been concerned with this provision because it lacks any guidance on the reimbursement arrangements for the use of equipment for a trial period. Additionally, it is unclear how the return of equipment from an unsuccessful patient would be handled.

Unreasonable financial loss could result if the dialysis equipment were returned after the trial period without payment. Such returned equipment could not be sold as a new medical product, and because of the impact of FDA requirements, it would be subject to rigid controls for testing and refurbishing before further disposition.

We recommend that the trial use of dialysis equipment needs further elaboration in the bill with respect to reimbursement considerations.

Incentives for reuse of dialysis filters. The bill authorizes the Secretary to conduct cost reduction experiments, including financial incentives to home dialysis patients, to clean and reuse their filters to the extent medically sound. We believe that this provision must be studied carefully to determine if the best interests of the patient would be served by such experiments.

Manufacturers of dialysis filters are presently labelling their product for single use because the potential contamination problems and certain reduction of effectiveness upon reuse. This policy, is, I believe, consistent with the sterile products policy of the FDA.

Even though reuse of dialysis figures has been studied in the past in selected treatment settings, we are not satisfied that the scientific evidence to date supports the concept of Government-sponsored experiments that include financial incentives to patients.

We are not opposed to experimental study of dialysis filter reuse, but are concerned that such experiments should have a sound medical and scientific basis for the participant and the sponsor.

In this context, we would like to recommend that the subcommittee give serious consideration to the dangers of offering financial incentives to patients for participation in a reuse experiment. Full information on the safety and efficacy of such a process should be obtained and any appropriate patient disclosures developed before financial incentives are offered.

Next, briefly, on reasonable cost reimbursement for dialysis equipment, there are provisions of the bill offering encouragements and incentives to the dialysis facilities to hold down dialysis costs on the purchase and utilization of equipment. Additionally, the House report on H.R. 8423 requests the Secretary to develop appropriate criteria and procedures to assure that equipment approved for purchase will be limited to equipment that is sufficient for the medical purposes required.

On this second point of sufficiency of equipment for medical purposes, we would like to note that FDA is already involved by virtue of recent amendments to the Federal Food, Drug, and Cosmetic Act, so that dialysis equipment and all other medical devices are subject to extensive controls related to safety and effectiveness of the product. Such controls provide an assurance to the program that dialysis equipment will be safe, effective, and sufficient for the medical purposes claimed by the manufacturer.

Accordingly, if criteria for purchase of dialysis equipment is to be developed, we think that it should address general economies of purchasing and utilization, and avoid comparative evaluations of product applications or performance.

My final brief concern deals with the improvement of administrative and reimbursement procedures. Manufacturers realize that the bill would introduce a number of new concepts in the procedures for reimbursement. The existing procedures for reimbursement have, at times, posed administrative problems especially for manufacturers who deal directly with the Social Security Administration.

We are encouraged by the extensive guidance in the bill to improve the reimbursement policies and controls and would like to suggest that the bill could be improved in its implementation by the reimbursement authorities if the committee report emphasized the need for consistent and timely systems for payments to, or on behalf of, manufacturers.

By virtue of this bill, the Secretary has a fresh opportunity to create new administrative efficiencies that will complement the major cost reduction features of the legislation.

This concludes my testimony. I now wish to provide my colleague, Bob Collins, with the opportunity to make a brief statement and request.

Mr. COLLINS. Mr. Chairman, I wrote to you on September 27 expressing our support and concerns about this bill. We would like this letter to be made a part of the hearing record.

Senator TALMADGE. Without objection, it will be inserted in the record.

Mr. COLLINS. To briefly summarize the major points of that letter, Cobe Laboratories has been concerned about the reuse incentive experiments. We think this is inappropriate until adequate studies and protocols have been worked through by the FDA, the clinicians and the cooperating manufacturers.

A second area of concern is the clarification of responsibilities and reimbursement in the following areas. One, reconditioning of the equipment; two, how home dialysis trials will be covered; three, preventive maintenance. We feel preventive maintenance should be an allowable cost and should be encouraged, as it is less expensive.

Finally, we think that some cost savings can be done in the area of encouraging timely reimbursement throughout the entire system. We find that accounts receivables of home patients, for an example, are much greater than the normal business practices. This obviously adds to the cost of doing business. Thank you.

[The letter referred to follows:]

COBE LABORATORIES, INC.,
September 27, 1977.

HON. HERMAN E. TALMADGE,
Russell Senate Office Building,
Washington, D.C.

DEAR SENATOR TALMADGE: Cobe Laboratories would like to take this opportunity to provide you and your committee with our comments regarding HR 8423 in its current form. The following outlines our current thoughts regarding House approval of these amendments (HR 8423) to the Social Security Act, Titles II and XVIII. Hopefully, the Senate can improve upon H.R. 8423.

Cobe Laboratories feels that the House bill overall has been well researched and written by the Health Sub-Committee of the House Ways and Means Committee. We feel that the legislation will be useful in achieving more effective cost control in the renal disease program by encouraging self-care dialysis and removing disincentives for kidney transplant. A major proportion of the proposed legislation also recommends changes in physician and facility reimbursement that includes prospective rates and incentives to economize.

We have identified some areas where improvements, mostly in the way of clarification could be made:

1. We are pleased that the proposed legislation is recommending reimbursement for capital equipment that goes home with the patient at 100 percent.

Provision is made for reconditioning and updating dialysis machines that have been purchased for home use. It is unclear relative to the assumption of product liability with regard to the center which modifies the equipment. Therefore, we suggest that this reimbursable service should be provided by a manufacturer's representative or his designate. The manufacturer will then be able to guarantee that the equipment will remain consistent with advanced research and technology and to continue to stand behind his equipment.

2. There appear to be several areas of necessary supportive services that have not been included in the proposed legislation.

- (a) Preventive maintenance contracts and routine service for home patient equipment should be included as allowable charges and reimbursed at 100 percent.

- (b) Home water treatment should be covered at 100 percent. (This is implied but not explicit.)

(c) Dietary counseling, social work, and other training should be covered for self-care patients in the home and institutional settings.

3. The proposed legislation provides many incentives for self-care dialysis at home or in renal dialysis facilities. However, the proposed legislation deals almost entirely with reimbursement recommendations for home dialysis. In reviewing Report No. 95549, from the House of Representatives, we do not find reimbursement recommendations for self-care dialysis provided by facilities. We recommend that facility-provided self-care dialysis also be reimbursed at 70-85 percent of the "screen". It is our observation that there is no recommendation for reimbursement of charges for self-dialysis training sessions which will be higher than for routine dialysis treatment. Medicare coverage currently sees the need for reimbursing at higher levels for training and has provided coverage at a higher rate for this training period. We would encourage that the new legislation include reimbursement at 100 percent for this training period. We feel this will add significantly to the incentive for encouraging patients to begin home dialysis or self-care dialysis.

4. The new legislation should also include encouragements to the Secretary of HEW for developing administrative procedures to minimize the time required for reimbursement to the facilities for the home training equipment and supplies. If this reimbursement takes longer than 30 days, it will have a significant negative impact on the cash flows of both facilities and manufacturers of the dialysis equipment and cause higher costs. Interest costs should be allowable for reimbursement which takes longer than 30 days.

5. The proposed legislation currently contains one short sentence relating to reuse of dialysis coils and artificial kidneys. We feel strongly that the reuse language should be modified. The ability of reuse is a complex issue being studied by manufacturers and providers. The medical safety and efficacy of reuse must be determined by a joint program of industry, physicians, and the FDA through the Bureau of Medical Devices. No incentives for reuse by home patients should be considered until data documenting the safety and efficacy of this process, along with directions for reuse, have been provided.

6. The proposed legislation recommends that the Secretary consider establishing maximum rates of returns for proprietary facilities. We feel it is not in the best interests of improved medical care for the Secretary to establish these maximum rates of return. This can best be addressed in setting prospective rates.

7. One of the most complex issues being dealt with in the proposed legislation is reimbursement. The proposed legislation encourages the Secretary to establish prospective and incentive reimbursement programs in order to reduce or minimize the increase of the costs per dialysis. The proposed legislation mentions that the subsequent cost savings can be shared by both the Medicare Program and the facility itself. We are concerned that this type of incentive reimbursement at times clouds medical judgment. Cobe Laboratories knows well that potentially medically insufficient dialysis can be obtained for less cost. Since we manufacture generally more expensive, high quality equipment and supplies with increased patient benefits, we hope that cost savings alone does not dictate the treatment and the equipment of choice.

9. It is also our understanding that the proposed legislation requests the Secretary to develop a list of "approved" equipment for home dialysis—"equipment that is sufficient for the medical purposes required". The FDA is already charged with this responsibility. We wonder if a duplicate charge to the Secretary is necessary.

If the Senate decides to hold hearings regarding the proposed legislation, Cobe Laboratories would appreciate the opportunity to present our insights in person at these hearings. We are encouraged by the proposed legislation and feel with the above mentioned additions that it will impact per patient treated costs within the End Stage Renal Disease Program.

Sincerely yours,

ROBERT M. COLLINS, *President.*

Senator TALMADGE. Thank you.

Any questions, Senator Dole?

Senator DOLE. I have no questions. I think you have made some good observations. I am sure the staff will address them. I appreciate it.

Senator TALMADGE. The next witness is Dr. Tipton McKnight, medical director, Earl K. Long Hospital, Baton Rouge, La., and George L. Bailey, Greater New Orleans Artificial Kidney Center.

Dr. McKnight, you may insert the full statement in the record and summarize it. As you know, this bill was introduced by your distinguished senior Senator last year and he deserves most of the credit for the development of it to the present time.

**STATEMENTS OF TIPTON McKNIGHT, M.D., MEDICAL DIRECTOR,
EARL K. LONG HOSPITAL, BATON ROUGE, LA., AND GEORGE L.
BAILEY, M.D., GREATER NEW ORLEANS ARTIFICIAL KIDNEY
CENTER**

Dr. McKNIGHT. Thank you, Senator. I am Tipton McKnight, a physician and medical director of the Earl K. Long Memorial Hospital in Baton Rouge. The program, has been in operation since 1972, and has been an extremely fine program to take care of the patients with end-stage renal disease in Louisiana. It has functioned well. We have been able to treat patients.

Let me share with you some of my experiences prior to that. In 1967, we had only three options in Louisiana. You had to move to another State, if you were required to be an in-center patient because we did not have any in-center dialysis at that time; you had to qualify for one of our home dialysis programs, or you had to die. Those were the only alternatives at that time.

The rigid criteria we used for selection of our patients allowed us to properly treat only 1 in 10 who had end-stage renal disease. Using only home dialysis, and with rigid selection, we experienced about a 30-percent-per-year mortality rate.

When funding became even more difficult for some of our programs during 1970 and 1971, we attempted reuse of coils & lines with the home patients. We had even more difficulties at that time. Since 1972, we have maintained about the same number of patients in home dialysis. That is 10 percent of our patients are probably still in home dialysis. The rest are in-center.

Our mortality rate has become acceptable for our overall patient population, 10 to 15 percent per year. I am concerned about some of the provisions of the bill, 8423, which provide incentives and sets goals for one form of treatment over another. I would hate to go back to 1967, 1968 and 1969 when the method of treatment that the patient got was based solely on a financial decision. There was no capability of making a decision between the physician and the patient as to the best type of therapy.

I think that we should remember to keep the reimbursement for renal disease on an equal basis, that is, self-care dialysis, in-center dialysis, and transplantation, and not try to dictate one form of therapy over another form based on financial reasons alone.

Remember that the program to date has been an extremely good program. Costs for treating a single patient have not gone up. This is remarkable for any program to treat a patient today, in 1977, for the same thing that he treated the patient for in 1973.

I think that we should carefully look at 8423 because it raises some questions that I believe would be very difficult to manage.

Dr. Bailey?

Senator DOLE. If I could interrupt, I have another meeting at 9:30. I wonder if I might put my statement in the record. I appreciate your statement. Dr. McKnight, what we are trying to figure out is how to contain the costs. The program at present costs a great deal per year per patient.

Maybe there is no option. Maybe you just have to pay because the alternatives are so bad, but an average of \$20,000 a year per patient is a pretty big cost for one program.

Dr. McKnight. No question, the cost is high. Also, there is no question that it is an effective program, Senator, because the alternative is not so good.

Senator DOLE. We must look at other alternatives of moderating the costs. We are going to be going into a large health program. And if this is going to be an example, it may have impact on others.

[The statement of Senator Robert Dole follows:]

OPENING STATEMENT OF SENATOR BOB DOLE

Mr. Chairman, I join you in welcoming those witnesses scheduled to testify today on the end stage renal disease program. I am particularly pleased to note that the witness list reflects not only health provider input, but also patient input. It seems that we too often forget to ask those most concerned with our health programs for their reactions and suggestions.

The issue cost containment seems to again prevail. Mr. Chairman. We have sat here together for many mornings over the past few months hearing testimony on how expensive health care has become and how best to control those costs.

The bill we have before us today is another cost control effort, as it relates to a specific program we are presently funding, and have found to be increasingly more expensive. But we must not forget that this legislation is also designed to assist patients in receiving the best possible care under the best possible circumstances for their needs.

Our first priority with this program, as with other federally funded health programs, is the patient.

When the end stage renal disease program was first enacted in 1973 as a part of the 1972 amendments, the estimated program cost in the fourth year of implementation was \$240 million dollars. This is our 4th year of implementation and the cost has risen to \$900 million already! A far greater sum than we ever imagined. Certainly we must look for the reasons why the costs have risen so high, and then direct our efforts to decreasing or otherwise bring under control, these costs.

Kidney disease leads to approximately 50,000 to 55,000 deaths each year. Access to dialysis and transplants, can prolong for many years the life of an individual.

The Federal Government has been deeply involved in research on the causes, treatment and prevention of kidney disease.

Both institutional dialysis and home dialysis have been looked at carefully. Also looked at carefully were those incentives and disincentives surrounding transplant therapy. The bill before us today reflects the findings of both the government and the private sector.

However, as with any other area in which a good deal of research has gone, there are differences of opinion on the best mode of treatment.

Today I expect we will hear differing opinions on the section of the bill that places an emphasis on home dialysis, and perhaps also on other sections of the bill.

These differences of opinion and the resolution of the many questions that will be raised because of the altering positions, are necessary to our effort to improve this program.

An article in the Washington Post last summer discussed the renal disease program and its implications. The closing remark warned us that, "Before we plow ahead with a national health insurance program, or a nationalized health care scheme for that matter, we must re-examine what we mean by health care

and what values we should apply in matters having to do, quite simply, with life and death." I thank each of you for being with us this morning to help examine a matter having to do with, quite simply, life and death.

Dr. BAILEY. My name is George Bailey, I am a clinical professor of medicine at Tulane University in New Orleans and head of the renal section there. I have had the opportunity to take care of patients with chronic renal failure in two very divergent settings. One is in the Northeast with a relatively well-to-do, well-educated population, with some poor patients that are disadvantaged, but the well-to-do were, by far, the greater number; and now, for the past 5 years, in the Deep South where I take care of at least 60 percent of my patients are the disadvantaged, ill-educated individual.

As such, I have had some very divergent opinions. I have long been associated with home dialysis programs and was the director of one, the first home dialysis program, and one of the largest ones in the country. I was very enthusiastic when I was able to put physicians and lawyers, the commanding general of the Greek Air Force, the United States, patients on home dialysis. Of course, I was able to set up units in France. I was able to set up a unit in Athens for a Greek general, and it was very fine. In fact, the Greek general's home dialysis program out there, I dare say, would not be comparable to anything in the country because he had a female physician trained to be his dialysis partner at home. I dare say his home dialysis costs were slightly greater than those that we have talked about today.

On the other hand, that is a situation where the patients are intelligent, the patients are educated, the patients are capable of comprehending and those patients are not stripped down to what I call the four basics of life, and that is love, food, God, and a good bowel movement. Whereas in our patients in the Deep South, they are subsisting on \$243 a month for a family, are stripped down to those four essentials of life, and they cannot worry a whole lot about the additional machine into their home that is going to be so very costly.

At least, if they worry about it, it takes second place to fulfilling one of those four basic primary objectives of life.

When we first began to use home dialysis we held out high hopes for it. The general thought at that time was that it might be a more convenient and less expensive form of accomplishing dialysis. My experience, unfortunately, is that these expectations are not being realized.

It is a proper form of treatment for suitable patients, however, the indiscriminate use of home dialysis can have severe repercussions for the patient and his family and can lead to an increase in patient mortality.

I recognize that many people still believe in home dialysis, that it is significantly less expensive than other forms of dialysis. This, indeed, was the medical expectation at one time. Unfortunately, what we have discovered as our experience has increased is that there is no inexpensive way of treating a patient with end-stage renal disease.

There are two forms of treatment that are less costly than hospital dialysis. It is home and limited care. Yet, we see these are closely related in cost.

The figures have been available for study in various years and Dr. Lowrie's presentation clearly stated that close approximation of the costs of these forms of treatment.

The more important issue, though, is the quality of patient care that is provided. As I mentioned earlier, my experience is that clearly home dialysis is not suitable for all. I bring out that point because we, at one time, as Dr. McKnight mentioned, were forced to put patients on home dialysis in Louisiana because it was the only form of therapy. We had a mortality rate of 30 percent per year and a morbidity rate that clearly was 10 times of that of center dialysis in any other part of the country, because we were trying to train patients that had as their objective goals those four basics of life, and they were struggling to meet these basic needs and the institution of this form of expensive, time-consuming effort into their lives was often more than the small amount of effort that life would allow.

I cannot overemphasize the fact that in prescribing this particular mode of therapy for end-stage renal disease a doctor is making a decision that affects the life of his patient and the entire family. Therefore, the principal issue should be, which treatment is best suited to each patient's needs, and obviously, this varies from patient to patient.

It should be obvious that there is a considerable difference between the suitability of patients for various social and economic and geographic areas that are suitable for someone who has a middle-class suburban income and social background may not be suitable for the low income, poorly educated patient anywhere in the United States.

To force physicians to ignore these factors because of an arbitrary national goal is to place the lives of these patients in jeopardy and to set this, not just as a national goal but a quota, is to pass a bill, should that come to pass, that would actually deal death to patients that are poor.

This does not make any sense to me. It is a giant step backward. Congress has literally saved the lives of thousands of men and women when it enacted this original program. To now jeopardize the lives of some of these patients in a misguided attempt to lower program costs, is just wrong.

As regarding transplantation, there is no replacement. There is no way to supplant a good, normally functioning kidney, and when one can achieve good transplantation, it is a thing of beauty to the health and welfare of that patient and his family.

Unfortunately, we, as physicians teaching and providing health care, have made no substantial strides in American transplantations in the last several years. It is the one major stalemate that is here in 1977. We have a chance of about 50 percent survival of a cadaver kidney, 30 percent at 2 years, 70 percent at 5 years.

I asked Congress to let us have the treatment that is available for the patient, not mandate it.

Senator TALMADGE. I agree with you, Dr. Bailey. This bill does not mandate the requirement that anyone must have dialysis treatment at home. Only where it is appropriate may he do so.

How profitable is your dialysis center?

Dr. BAILEY. We have one of the free-standing dialysis units. I get physician fees, which we use to support our department at the university. In fact, that is the only budget the university department has. It has no budget. We pay for it all out of our physician fees at the kidney center.

I can answer to what is the profitability of the overall center—
 Senator TALMADGE. Your fees are allocated to the hospital?

Dr. BAILEY. No, sir. My physician's fees are allocated to it. Out of our physician's fees we pay for fellowships, salaries for physicians in the university that are in training. We pay for student training, pay for the cost of the kidney laboratory.

Senator TALMADGE. Whatever profits are made over and above the fees, to you, as a physician for service, are allocated to the maintenance of the unit?

Dr. BAILEY. No, sir, we have a free-standing unit. We have two situations going on. I am in charge of the Tulane section of the Charity Hospital in New Orleans, which means the Charity Hospital gets the large reimbursement of \$6.60 per dialysis from the Social Security Administration because of problems which we have not been able to solve with the bureaucracy of social security.

They do not even come close to reimbursing Charity for any of its cost.

On the other hand, in a private unit where we accept Charity Hospital patients on a part-pay basis, our private unit is privately owned. It has been financed by the national company. We take the physician's fees and use them for our own income and for the support of our university department of both medical schools, and the profits that accrue from the dialysis units are those to the national company.

Senator TALMADGE. Do you or your associates have any part ownership in that operation?

Dr. BAILEY. No, sir.

Senator TALMADGE. Thank you very much, gentlemen. We appreciate your contribution.

[The prepared statement of Drs. McKnight and Bailey follow:]

TESTIMONY OF TIPTON MCKNIGHT, M.D.

SUMMARY

(1) To date the end-stage renal disease program has demonstrated the ability of government, private insurance facilities, physicians and patients to work together to provide life saving highly specialized services to patients who need them.

(2) Reimbursement should be equal for all forms of therapy, i.e., self-care dialysis, in-center dialysis and transplantation.

(3) H.R. 8423 extends benefits to patients with end-stage renal disease which are admirable.

(4) H.R. 8423 if enacted, would place in jeopardy the strong points of the end-stage renal disease program.

STATEMENT

My name is Tipton McKnight. I am a physician, a nephrologist and the Medical Director of the Earl K. Long Memorial Hospital in Baton Rouge, Louisiana. At the outset of my discussion of the end-stage renal disease program, I would like to say this has been outstanding legislation for the patient with end-stage renal disease. The lives of many people have been saved by the enactment of this program in 1972. From the cost-effectiveness point of view, it has been the best piece of legislation relating to health care that has ever been passed. The cost of treating a patient today is virtually the same as the cost of treating that patient in 1972. In no other area of health care has cost containment functioned so well while permitting the patient to receive quality services in an on-going manner.

In addition, facilities, patients and physicians have known what to expect in reimbursement. The ability to render services to patients has been expanded without costly duplication of facilities. Nephrologists have been trained to care for these patients without costly crash programs which produce an increasing number of physicians in a specialty. In short, the end-stage renal disease program and

the history of the renal disease program in a short span of five years has been one of cooperation between government, facilities, physicians and patients and the success of this program in delivering complex self-care to a specialized group of citizens in a very cost effective manner has far exceeded any other health care program ever undertaken in this country.

Before specifically addressing issues raised by HR 8423, I would like to share with you some of my experiences and patient data.

From 1967 to 1972, there were only three alternatives for the patient who required chronic hemodialysis in Louisiana. Those alternatives were: 1) move to another state that had chronic hemodialysis in-patient facilities; 2) qualify for one of the home dialysis programs; or 3) to die. Because of the fairly rigid criteria that existed with regard to accepting patients for chronic hemodialysis at this time, 50% of the patients who could have benefited from this service were automatically eliminated. Of the patients remaining, because of limited facilities and funding, only one patient in five could be accepted for a chronic home dialysis program. Gentlemen, this meant that out of every ten patients with end-stage renal disease in Louisiana, who could have benefited from chronic hemodialysis only one was actually able to get on dialysis and that one was forced to do home dialysis. Even though these people were unquestionably highly motivated to use home dialysis, we experienced a 30% per year mortality rate. When funding became difficult during 1970 and 1971, we attempted to save money by reusing coils and lines at home. We found, however, that this compromised the health of our patients and that there was an alarming increase in sickness and death in our patient population.

From 1972 to 1977 we have followed the national trend, and the number of patients who have been placed on home dialysis has declined. You can see from the previous statement that this is not a decline in the percentage of home patients. It remains at about a 10% level, which is what the rate was when we only had home dialysis available to us. Now, with alternatives available such as center dialysis, our mortality rate has been reduced to only 10-15% per year, consistent with the national average.

Transportation poses different problems. In our experience in Louisiana, results have been good when we have had a suitable, closely related living donor. On the other hand, results with cadaver transplantation have been notoriously poor. Transplantation with cadaver kidneys results in higher mortality and morbidity rate. When patients are doing well on dialysis, I have serious problems justifying subjecting them to cadaver transplants. The state of the art is not yet sufficiently advanced so as to justify other than carefully selected cadaver kidney transplants.

Another concern I have relates to the provisions in the bill which provides incentive payments in order to encourage patients to select one form of treatment over another. While I support increasing and extending coverage to patients with end-stage renal disease, I believe this should be applied uniformly. I would hate to return to the method of treating patients we had to employ in 1969, when the availability of reimbursement was the major determinant as to the type of care the patient receives. Gentlemen, now is not the time to regress and allow the method of treatment for a patient to be determined by his or her ability to pay. To insure quality medical care that the people of Louisiana deserve, you must leave the selection process in the hands of the physician and the patient.

In summary, HR 8423 extends benefits to patients with end-stage renal disease which are admirable. However, other provisions in the bill raise questions and issues that threaten to destroy a very successful program. Therefore, in closing I would urge you: (1) Keep reimbursement equal for all forms of therapy, i.e., self-care dialysis, in-center dialysis and transplantation. (2) Remember that to date the end-stage renal disease program has demonstrated the ability of government, private insurance facilities, physicians and patients to work together to provide life saving highly specialized services to patients who need them.

(3) HR 8423 if enacted, would place in jeopardy the strong points of the end-stage renal disease program. Certainly it would be unwise to jeopardize the fine record of the renal disease program by passing this bill.

TESTIMONY OF GEORGE L. BAILEY, M.D.

SUMMARY

An objective review of the available data will demonstrate that:

1. Home dialysis is not significantly less expensive than limited care dialysis. There is no "inexpensive" way to perform dialysis.

2. The decrease in use of home dialysis pre-dated, and hence is unrelated to the reimbursement provided by the End-Stage Renal Disease Program.

3. The high percentage of home dialysis achieved by England has been done at the expense of most patients being denied access to dialysis.

If Congress is truly concerned about the quality of patient care, it will not mandate the form of treatment to be provided.

My name is Dr. George L. Bailey, and I am Professor of Medicine at Tulane University Medical School in New Orleans. I have been actively involved in taking care of patients with kidney failure for fifteen years. Moreover, I have been involved in the home dialysis program since its very early days.

When we first began to utilize home dialysis, we held out high hopes for it. The general thought at the time was that it might be a more convenient and less expensive method of accomplishing hemodialysis. My experience, unfortunately, is that these expectations have not in fact been realized. Home dialysis is, of course, a proper form of treatment for suitable patients. However, the indiscriminate use of home dialysis can have severe repercussions for the patient and his family, and can lead to an increase in patient mortality.

I recognize that many people still believe that home dialysis is significantly less expensive than other forms of dialysis. This indeed was the medical expectation at that time. Unfortunately, what we have discovered, as our experience has increased, is that there is no "inexpensive" way to treat a person with end-stage renal disease. There are two forms of treatment which are less costly than hospital dialysis—home and limited care dialysis. Yet we have found that these are very closely related in cost. The figures have been available to study for several years. It seems to me that to resolve the cost controversy, Congress or HEW can simply undertake to do an independent analysis similar to Dr. Lowrie. At any rate, an objective determination as to cost is possible, and I would recommend that such an analysis be done.

A more important issue, though, is the quality of patient care that is provided. As I mentioned earlier, our experience is clearly that home dialysis is not suitable for all. We had terrible problems in Louisiana when home dialysis was the only form of treatment available. The legislation before this committee would establish a "national goal" that a majority of new patients either undergo home dialysis or be transplanted. This causes me great concern.

I cannot overemphasize the fact that in prescribing the particular mode of treatment for end-stage renal disease a doctor is making a decision that affects the life of his patient. Therefore, the principal issue should be which treatment is best suited to a patient's need. Obviously, the need varies from patient to patient.

It should be obvious that there is a considerable difference between the suitability of patients from various social, economic and geographic areas. What is suitable for someone who has a middle-income suburban family background may not be suitable for a person with a low-income, urban background. To force physicians to ignore these factors because of an arbitrary national goal is to place the lives of these patients in jeopardy. This does not make any sense to me. It would be a giant step backwards. Congress literally saved the lives of thousands of men and women when it enacted this program. To now jeopardize the lives of some of these patients in a misguided attempt to lower program costs is just wrong.

I recognize that the national goal involves both home dialysis and transplantation. I wish that I could believe that a significant number of patients could successfully undergo transplantation, but that is simply not the case. Absent a suitable, closely related donor, the state of the medical art for cadaver transplantation has not sufficiently progressed to where we can realistically expect a significant increase in transplant success. Again, this is where I have great concern over the "national goal" provisions of the bill. To encourage physicians to transplant when a patient would otherwise be suitable for in-facility dialysis at this time is just not right. When, and if, cadaver transplants have high success ratios, you will not have to mandate any percentage for transplants. They will certainly be prescribed and performed when appropriate. Until that time, though, you are seriously placing patient lives in danger by setting a national objective.

Two other points I would like to address briefly before closing. The first deals with the question of why home dialysis use has decreased and the second deals with the British rate of home dialysis. I am aware that controversy surrounds both these issues, but I also believe they are capable of objective resolution.

Concern has been expressed in Congress that the percentage of people using home dialysis has decreased since the End Stage Renal Disease Program was

implemented. I am familiar with the testimony presented by Dr. John Merrill of the Harvard Medical School at hearings held at the Ways and Means Committee last April. I should mention, at this time, how important I believe it is for this Committee to hear from Dr. Merrill, who is the pioneer and leader in the treatment of end-stage renal disease in the United States. Dr. Merrill should certainly be given the opportunity to appear and testify. During that testimony, he presented data which clearly showed that the total number of center patients increased disproportionately to the increase in home patients beginning in July of 1972, a year before the ESRD program was implemented. The fact that the increase in center patients antedated the enactment of the program suggests that the medical factors I have outlined accounts for this occurrence rather than the legislation. If doubts persist as to this, however, an independent analysis of Dr. Merrill's data can certainly resolve the issue, rather than to continue to have people mistakenly believe that a cause and effect relationship exists between the implementation of the program and a decrease in home dialysis.

Finally, one word with regard to the figure that is frequently given that England has 65 percent of its patients on home dialysis. England is being highly selective in accepting patients for treatment. In fact, about 75 percent of patients who could be treated for end-stage renal disease in England die without treatment. I do not believe we should attempt to do the same thing here.

Senator TALMADGE. Our final witness today is Dr. Alan Hull, Chief of Clinical Nephrology, Parkland Hospital, Southwestern Medical School, Dallas, Tex.

Dr. Hull, you may insert your full statement in the record and summarize it, sir.

Mr. MADISON. Mr. Chairman, I am not Dr. Hull. Staff has suggested that I fill in his slot. I am Richard Madison, president of the Kidney Foundation of Massachusetts, sir.

STATEMENT OF RICHARD MADISON, PRESIDENT, KIDNEY FOUNDATION OF MASSACHUSETTS

Mr. MADISON. Thank you, Mr. Chairman. With your permission, and in the interests of time and brevity, in fact I would kind of like to skip ahead in my statement and let the laudatory things that I do have in my statement stand for the record.

If I may jump ahead to the essence of our comments, first of all, I consider that we, like many of the others who have testified today are, in fact, patient advocates. We endorse heartily those sections of the bill that provide more adequate funding for self-dialysis and transplantation programs and, once again, to repeat the thoughts of many others, specifically for those patients who are best-suited to these modes, also we endorse any studies, experiments, cost-benefit, statistical reports by the Secretary of HEW to the Congress relative to the progress that we are making in these areas. It has been to these points that the Kidney Foundation of Massachusetts has, in fact, testified to at earlier times and in earlier testimony and the foundation has, in fact, commissioned a preliminary cost study by Peat, Marwick & Mitchell, which you have in your printed hearings on page 241.

We are delighted that we have made as much progress in the bill as we have. However, we are disturbed that the language relative to mandatory quotas and modality of treatment seem to us to have been retained in the bill; while the language has been revised, it seems somewhat contrary to Dr. Weinstein's feelings that these mandated quotas seem to be more stringent than they were in the original proposal.

In section 9(c) (4) which states that both national objectives with respect to the appropriate proportion of patients in self-dialysis centers have prepared for our undertaking transplantation of a majority of new patients being accepted for treatment should be in self-dialysis settings, or be transplanted.

The original provisions call for 40 percent of the patients should be in self-dialysis by 1978 and 50 percent by 1980. These quotas were judged as not realistically attainable by most witnesses, as noted on pages 12 and 13 of the staff report.

The present bill now requires at least one out of every two patients accepted into the ESRD delivery system be forced by what is effectively legislative mandate into transplantation or self-dialysis. We feel that this decision should be based solely on medical factors, and we strongly urge that this language be eliminated from the bill.

In fact, we feel that the incentives for self-dialysis and early transplantation, if they are, in fact medically valid, that they should stand on their own. We do not feel that this is necessary to make statistical arbitrary mandates when, in fact, there is a good incentive to develop this program.

We are further distressed that the legislation provides a double standard which we feel effectively penalizes those who may not qualify for self-care by reasons of medical, emotional or economic disfavor. I refer on page 4 of the bill which we feel discriminates to the segment of the end-stage renal disease patient by imposing an economically punitive waiting period.

We would urge the Congress in its wisdom to aid equally those patients who share an equal life-death problem by providing from the very first stage of treatment for all.

In summary, the Kidney Foundation of Massachusetts supports and endorses the concept of economical, life-saving health care services consistent with the best medical judgment and the sociological circumstances, needs, and wishes of the patients.

Thank you very much for your interest.

Senator TALMADGE. Thank you very much for your contribution, Doctor, and I thoroughly agree with you that we ought not to try to assign any arbitrary quotas. Dialysis, in my judgment, must be a medical judgment to be made by a qualified doctor. For some, it would be appropriate; for others, inappropriate.

[The prepared statement of Mr. Madison follows:]

TESTIMONY OF RICHARD MADISON, PRESIDENT, KIDNEY FOUNDATION OF MASSACHUSETTS

Mr. Chairman, Members of the Committee, Gentlemen—My name is Richard Madison. I am president of the Kidney Foundation of Massachusetts. As spokesman for a major voluntary health agency, concerned with all aspects of renal diseases—patient care, public and professional education, renal research and the organ donor program—I am grateful for the opportunity to share our views with this Committee relative to H.R. 8423.

Let me say initially that my predecessor as President of the Massachusetts Kidney Foundation, Charles E. Westcott, made suggestions by letter on September 23, 1975 to Representative Charles A. Vanik, Chairman of the Subcommittee on Oversight of the House Ways and Means Committee and testified personally before the Subcommittee on Health and the House Ways and Means Committee on April 25, 1977.

As a result of that testimony, the testimony of other learned witnesses and the wisdom of the Congress, a constructive proposal for improvements in the present program for End Stage Renal Disease (ESRD) patients has evolved.

We endorse those sections of HR 8423 that provide more adequate funding for self-dialysis and transplantation programs for those patients best suited to these modes, as well as for studies, experiments, cost benefit and statistical reports by the Secretary of Health, Education, and Welfare to the Congress, relative to the progress and status of the ESRD program. It was to these points that the Kidney Foundation of Massachusetts testified earlier¹ and in fact, commissioned a preliminary cost study to point out the inadequacy of existing cost information relative to self-dialysis, transplantation, and dialysis in an institutional setting. We are delighted this informational review and fact gathering has been incorporated into the current bill.

We continue to be disturbed, however, that mandatory quotas on modality of treatment have been retained in the bill and, while the language has been revised, it appears to us, that the mandated quotas appear to be more stringent than in the original proposal.

I refer to section (9) (c) (4) which states that "the national objective with respect to the appropriate proportion of patients in self-dialysis settings and preparing for, or undertaking, transplantation is that a majority of new patients being accepted for ESRD treatment should be in self-dialysis settings or be transplanted." (underlining added)

The original provisions of H.R. 3112 called for 40 percent of patients to be in self-dialysis settings by 1978 and 50 percent by 1980. These quotas were judged as not realistically attainable by most witnesses as noted on page 12 and 13 of the Staff Report to the House Subcommittee on Health Care (Document WMCP95-38).

The present bill (HR 8423) requires that at least one of every two patients accepted into the ESRD health care delivery system will be forced by legislative mandate into transplantation or self-dialysis. These decisions, we believe, should only be based on medical factors and decisions. We strongly urge that they be eliminated from this bill.

If, in fact, the incentives for self-dialysis and early transplantation, presently being considered, are medically valid, they should more than adequately increase these modalities without Congress setting life or death percentile standards, based on the presumption of cost savings, a presumption which, incidentally, is seriously in doubt in light of the most recent evidence!² Perhaps it would be appropriate for Congress to investigate and resolve this conflicting testimony.

We are further distressed that the proposed legislation provides a double standard which effectively penalizes those who may not qualify for self care by reasons of medical, emotional or economic disfavor (disadvantage). I refer to page 4 (line 5, etc.) of the bill, which we suggest discriminates against a segment of the End Stage Renal Failure patient population by imposing an economically punitive waiting period, often on those who can least afford to be penalized. We would urge the Congress, in its wisdom, to aide equally those patients who share an equal life-death problem by providing from the first day of treatment—for all.

In summary, the Kidney Foundation of Massachusetts supports and endorses the concept of economical, life saving health care services, consistent with the best medical judgement and the sociological circumstances, needs and wishes of the patient.

Thank you for your interest and invitation to express our views on this important legislation.

Senator TALMADGE. For the information of those who are here, the staff has prepared some background material relating to H.R. 8423, this little blue pamphlet I hold in my hand. There are copies over here on the table that are available for any of you who would like to take it with you and study this matter further.

This completes our hearings on this matter, and also the cost containment bills presently pending before this subcommittee, and we hope that the Finance Committee can meet one day next week and mark up and order reported H.R. 8423 with some appropriate amendments that the subcommittee will recommend to the full committee.

¹ Hearings, Apr. 25, 1977 (see printed hearings records pp. 236-254).

² Peat, Marwick and Mitchell study, Apr. 23, 1977, p. 241.

The subcommittee will stand in recess, subject to the call of the Chair.

[Thereupon, at 9:55 a.m., the subcommittee was recessed to reconvene at the call of the Chair.]

[By direction of the chairman, the following communications were made a part of the record:]

U.S. SENATE,
COMMITTEE ON ENERGY AND NATURAL RESOURCES,
Washington, D.C., October 11, 1977.

HON. HERMAN E. TALMADGE,
U.S. Senate,
Washington, D.C.

DEAR HERMAN: We are writing to you to express our strongest possible support for H.R. 8423, a measure you will consider in hearings on October 21.

This measure has passed the House of Representatives. It is our hope that your Subcommittee on Health and the full Finance Committee would approve this legislation at the earliest possible time.

We are enclosing a copy of a statement made by Dr. Belding H. Scribner, a distinguished physician, who is the head of the Division of Kidney Disease at the University of Washington in Seattle. Dr. Scribner has been a pioneering figure in national efforts to deal with kidney disease. His development of the "Scribner Shunt" made chronic dialysis possible. We are proud of our association with him in his efforts at the University of Washington, where he has led many hundreds of our citizens to useful lives despite a disease that would have recently been a death sentence.

We respectfully request that Dr. Scribner's statement be enclosed as part of the record of the hearings. That statement makes it clear that it is imperative that Medicare regulations be altered to encourage rather than discourage home dialysis.

Our staffs have worked with your Mr. Constantine, who has been very helpful.

With warmest wishes,

Sincerely,

WARREN G. MAGNUSON,
U.S. Senator.
HENRY M. JACKSON,
U.S. Senator.

Enclosure.

STATEMENT BY BELDING H. SCRIBNER, M.D., PROFESSOR OF MEDICINE, HEAD OF THE DIVISION OF KIDNEY DISEASES, UNIVERSITY OF WASHINGTON, SEATTLE, WASHINGTON.

Last spring I testified before Mr. Rostenkowski's Subcommittee on Health of the Committee of Ways and Means in support of H.R. 8423. In that testimony I provided detailed documentation for two major points: 1) Home dialysis can be as much as 50% less costly than in-center dialysis, and 2) that for most patients self-care dialysis either in-center or at home where the patient takes the major responsibility for his own well-being is better medical therapy than in-center dialysis where the staff provides the service. A major objective of H.R. 8423 is to alter the Medicare regulations which presently discourage home dialysis so as to provide positive incentives for home care. I believe the legislation as finally passed by the House of Representatives can achieve this important goal. And I want to congratulate Mr. Rostenkowski, Mr. Vanik and the Committee for responding so diligently to the suggestions made in the testimony given at those hearings last spring. I fully support the legislation as currently drafted except for one point. I would urge the Committee to consult with the Bureau of Health Insurance regarding the appropriate "target rate" for home dialysis, and consider whether a figure of say 75 percent may be more appropriate than 70 percent. While I am certain that our costs in Seattle are below the 70 percent figure, it is possible that there are situations where a figure as high as 75 percent might be required, especially in the start-up phase of a new program. I would hate to see home dialysis curtailed in any way by making this absolute limit too low. With this one exception, I support with genuine enthusiasm this im-

portant piece of legislation which may become a landmark in terms of cutting costs while at the same time improving patient care.

I have two additional suggestions regarding recommendations that the Committee might make regarding the implementation of this legislation:

(1) While H.R. 8423 provides incentives to patients and to facilities to perform home dialysis, it does not address the problem of providing an incentive for physicians. Medicare reimbursement to physicians can be made an appreciable incentive to physicians to encourage their patients to perform home dialysis. The majority of nephrologists are reimbursed by the traditional fee for service method for care of their dialysis patients, as opposed to those physicians who have elected the so-called alternate method which provides a comprehensive monthly fee for services to home dialysis patients. Present instructions from the Bureau of Health Insurance insist that a physician must elect only one or other method of payment for all of his patients, whether they are dialyzing at a facility or in the home. Consequently, those physicians reimbursed by fee for service who are presently caring for facility dialysis patients would be eligible only to receive reimbursement for office calls for any of their patients who went to home dialysis. The Bureau of Health Insurance, recognizing the many supporting services of the physicians which are required by home dialysis patients in addition to the office visit, does provide for these services through the alternate reimbursement method. Consequently I would recommend that the committee direct the Bureau of Health Insurance to permit physicians who are reimbursed by fee for service for their in-center dialysis patients to be able to elect reimbursement by the alternate method for those of their patients who are treated by home dialysis.

In addition, I would like to point out that an important additional incentive for home dialysis would be to pay physicians the same professional fee whether the patient be at home or in the center. Currently, for home dialysis patients the physician receives only 70 percent of the reimbursement that he receives if the same patient is treated in the center. I have always felt this to be inequitable, since the total physician involvement is roughly the same for both modalities. In a program like ours in Seattle, 70 percent of patients go home, as compared with the national average of 15 percent. Hence, in the interest of good patient care, our doctors are voluntarily making a considerable financial sacrifice. Correction of this inequity would be an excellent incentive to encourage home dialysis and would not result in any overall increase in the cost of physician services to the program.

2) I have developed a major concern over the definition of self-care in a center. If for the purpose of satisfying the intent of this legislation self-care in a center is to be equated with home care, then the definition of what constitutes in-center self-care must be very carefully drawn. A major goal of this legislation is to encourage the patient to do as much as possible for himself either in-center or at home. If centers are permitted to claim that self-care which involves only minimal patient participation fulfills their obligation to meet network goals for true self-dialysis, a major objective of the legislation will be put in jeopardy. This problem is both delicate and difficult, and I can offer no easy solution to it.

In summary, I would urge the Committee to approve the legislation in its present form and work for its passage with all deliberate speed.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., September 27, 1977.

Senator HERMAN E. TALMADGE,

Chairman, Subcommittee on Health, Russell Senate Building, Washington, D.C.

DEAR MR. CHAIRMAN: I am taking the liberty of forwarding to you a letter which I have just received from the chief administrative officers in all of the hospitals in my Congressional District.

The letter reviews various issues of concern to these administrators in the current debate over hospital cost containment legislation.

One of the key points made in this letter is that Indiana's Hospital Rate Review Committee has done a good job of keeping hospital costs under control in Indiana.

I would be very grateful if you could give my constituents' views very careful consideration during the Senate's deliberations on hospital cost containment.

With best wishes.

Sincerely,

JOHN BRADEMAS,
Member of Congress.

Enclosure.

SEPTEMBER 26, 1977.

Congressman JOHN BRADEMAS,
Longworth House Office Building,
Washington, D.C.

DEAR MR. BRADEMAS: The undersigned represent general hospitals serving health care needs of citizens of the Third Congressional District. We are deeply concerned that legislative proposals before Congress may wreck an effective and proven Indiana system for the containment of hospital care costs. We fear that such legislation may result in discriminatory and inequitable rate setting and, more importantly, a denial of needed health care services to our citizens.

The effectiveness of Indiana's voluntary Hospital Rate Review Committee is demonstrated by figures reflecting actual 1976 hospital care costs and published in the 1977 edition of the American Hospital Association Guide to the Health Care Field. The average Indiana per diem in-patient cost of \$128.83 was 14.8 percent less than the national average of \$151.28. The average Indiana in-patient case cost of \$1,017.74 was 12.6 percent below the national average of \$1,164.48.

Illinois does not have a rate review system and we have obtained figures from that state for the last three months of 1976 to compare with Indiana experience for November and December of 1976 and January of 1977. Indiana in-patient per diem revenues averaged \$137.29 or 19.9 percent less than Illinois revenues of \$171.53 while costs averaged \$132.56 or 18.6 percent less than Illinois' \$162.90 costs. During this same period the average length of patient stay in days was about the same, 7.20 in Indiana and 7.05 in Illinois.

Indiana's Hospital Rate Review Committee composed of knowledgeable laymen, including consumer representatives, and health care professionals has demonstrated its competency since 1960. It allows hospitals to begin an orderly process of financial planning six months prior to each budget year. Proposed rates supported by documented evidence of related costs are reviewed and determined for the next budget year in approximately three months. The review by the committee is tough but fair on a hospital by hospital basis. The approved rates cover all reasonable financial needs of each hospital and allow that hospital to provide appropriate health care services to all of its patients. It should be noted that the Hospital Rate Review Committee cooperates fully with agencies administering existing federal health planning legislation.

In fact, it is disturbing to learn that the Carter Administration and Congress are considering further legislation without giving adequate time for existing legislation to impact on hospital and other health care costs. A case in point is Public Law 93-641, the National Health Planning and Resources Development Act of 1974. The Northern Indiana Health Systems Agency organized under this act has been operating for less than a year under its first Health Systems Plan and Annual Implementation Plan and, like most of its sister agencies, is still waiting full designation by HEW. Nevertheless, this agency does have effective review authority over hospital capital investment programs for new buildings and equipment and has already demonstrated its willingness to block such expenditures on the basis of excessive capacity or duplication. Professional Standards Review Organization review procedures also need adequate time to demonstrate their contribution to the goal of reasonable containment of hospital costs.

We are particularly concerned about the concept of a percentage "cap" on total revenue increases for a given fiscal year for each hospital. While various formulae have been suggested, the end result usually is expressed as a 9 percent cap. Using the Administration proposal as a base, one of our hospitals has estimated that the effective revenue cap for its 1978-79 fiscal year would be 5 percent over 1977-78, which is less than the current rate of inflation. Budgets for both fiscal years would be affected immediately.

Under the Administration proposal, a hospital in this situation probably would have no choice but arbitrarily to refuse services to some patients. Entire service units might well be eliminated, particularly primary, non-acute care units serving

the indigent with their high cost/low revenue ratios. Since patients need these health services, the ultimate effect would be either a general deterioration of the health of these patients or a turning to unregulated and expensive alternative agencies for care or both.

Another serious problem is the likelihood that proposals now under consideration would penalize most heavily hospitals like those in Indiana which have kept rates to a minimum through an effective containment program. Hospitals with relatively excessive rates, on the other hand, would have the opportunity to increase rates without exceeding a revenue cap before either cutting questionable costs or reducing or eliminating patient care services. Another opportunity for unfair discrimination between hospitals are proposed exemptions of Veterans Administration, Health Maintenance Organization and other favored hospitals from cost containment controls.

A fundamental problem with the across-the-board approach to hospital cost containment is that many costs are effectively beyond the control of the trustees and administrators of the hospitals. The decision to provide services is the decision, not of the hospital, but of the physician in private practice evaluating the needs of his patients. This is not to say that hospitals and physicians cannot work together to eliminate unnecessary services. In fact, we are already seeing positive results from utilization review procedures in the hospitals of the Third District.

Malpractice insurance premium costs have risen steeply for all of our hospitals without visible correlation to actual experience in such claims. We are, of course, at the mercy of inflation in the marketplace in the purchase of heat and power, supplies, etc. In the area of wages for hospital staff we have witnessed the pressure for our personnel to catch up with persons employed in the private sector, pressures difficult to resist when quality of care to patients is our bottom line. Moreover, hospital employees today often require a high degree of training and technical skills.

In the long run, unrealistic and insensitive cost controls imposed on hospitals can only stifle innovative and progressive planning to provide services needed by patients—including those made possible by new technologies—and paid for through reasonable rates. Such planning is basic to implementation of Public Law 93-641, which would have to be abandoned for all practical purposes to accommodate short-run cost decisions.

While we sincerely believe that federal hospital cost containment legislation is not needed in Indiana, we recognize that problems elsewhere in the nation may persuade Congress to act. Any attempt to place a gross cap on revenues in such legislation would be a disastrous mistake. We urge that you, as a leader of the party in power in Congress, support the concept of a hospital by hospital review within each state to establish rates covering the reasonable financial needs of each hospital in enacting any such legislation.

We further ask your support in such legislation of provisions that recognize and preserve effective and proven cost containment programs in states like Indiana. If the voluntary approach of Indiana's Hospital Rate Review Committee is not acceptable, then we ask that reasonable time be given for the Indiana General Assembly to give statutory authority to the system.

In closing, we would like to express our warm appreciation for the recent opportunity some of us had to meet with you personally to discuss our concerns. All of us stand ready to provide you with additional information on our own experience under the Indiana hospital cost containment system and to share that information with appropriate committees of the Congress.

Sincerely,

Sister Mary Agnes, Administrator, St. Anthony Hospital, Michigan City; David Kramer, Administrator, LaPorte Hospital; P. Donald Muhlenthaler, Administrator, Walters Hospital, Michigan City; Norman Steider, Administrator, Memorial Hospital, Michigan City; Richard W. Trenkner, Administrator, Memorial Hospital, of South Bend; Stanley Fleece, Administrator, South Bend Osteopathic Hospital; Sister M. Maureen, F.A.C.H.A., Administrator, St. Joseph Hospital, of Mishawaka; Warren Phemister, Chief Executive Officer, Goshen General Hospital; Dale Strassheim, President, Elkhart General Hospital; and David C. Trew, Administrator, St. Joseph's Hospital, South Bend.

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION,
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO appreciates the opportunity to submit its views with respect to S.1391 and a new proposed version of S. 1470 not yet formalized into a bill.

Since the AFL-CIO has already testified at length on both S. 1391 and S. 1470, this statement will, therefore, restrict our comments to the extent, if any, that S. 1391 and the proposed alternative approach to S. 1470, which has been outlined by Senator Talmadge, meets the principal objections we raised in our prior testimony on both bills.

Our principal objections were:

Both bills interfered with free collective bargaining and directly or indirectly controlled wages.

S. 1391, but not S. 1470, allowed the delegation of cost control to six states. The AFL-CIO position was that cost control should be a national program with uniform standards and uniform administration.

A federal cost containment program should be temporary so as not to close out the options available to the Administration with respect to cost containment under a national health insurance program which is to be submitted to Congress no later than March 31, 1978.

Unfortunately, neither S. 1391 nor the alternative approach to hospital cost containment as outlined by Senator Talmadge meet our objections.

FREE COLLECTIVE BARGAINING

Originally, S. 1391 exempted six states: Connecticut, Massachusetts, Maryland, Washington, New York and New Jersey from the federal program. We indicated our reluctant willingness to accept the delegation of responsibility for hospital cost control to these states provided there was a requirement in the state law for a mandatory pass-through of wage increases for nonsupervisory employees as was clearly stated by President Carter in his health message. The message stated that state hospital cost containment programs should allow for "an adjustment for hospitals which provide wage increases to their nonsupervisory employees." Unfortunately, S. 1391 now not only allows the original six states to be exempt from this standard, but adds one more, Wisconsin.

The revisions suggested by the distinguished Chairman of the Health Subcommittee to S. 1470 greatly simplify the wage control provisions of the original bill but do not alter its intent which is to place a ceiling on wage increases. The AFL-CIO cannot accept this.

DELEGATION OF COST CONTROL TO THE STATES

One of the desirable provisions of the original Talmadge Bill was that it established a national federally administered program. This desirable feature of S. 1470 would be removed by the proposed alternative approach. States would be authorized to substitute state hospital cost containment programs for the national program.

S. 1391, as reported out by the Human Resources Committee, is also a retreat from the Administration's Bill as originally introduced. The bill now would provide start-up grants to any state to help it establish a state rate review commission. This would be contrary to the approach of the Kennedy Health Security Bill (S. 3) which the AFL-CIO has vigorously supported and which would contain health care costs through a national program of budgeting health care expenditures.

It should be pointed out that both S. 1391 and S. 1470 would, however, be compatible with the extension of private health insurance as proposed by the Health Insurance Association of America and the American Hospital Association. Both S. 1391 and S. 1470 would thus preempt the options available to the Administration in developing its national health insurance plan.

TEMPORARY PROGRAM

It is such considerations that led the AFL-CIO to urge that any hospital cost containment program should be limited to a period of no more than eighteen months so that a permanent hospital cost containment program could be introduced at the same time the President unveiled his national health scheme and be compatible with it. President Carter has pledged to introduce his bill by March 31, 1978. This is now less than six months away.

The AFL-CIO, therefore, opposes hospital cost containment legislation at this time and strongly recommends action be deferred at least until the Administration introduces its national health insurance program next March.

STATEMENT OF DR. FELIX E. DEMARTINI, EXECUTIVE DIRECTOR, PRESBYTERIAN HOSPITAL IN THE CITY OF NEW YORK AT THE COLUMBIA-PRESBYTERIAN MEDICAL CENTER

Mr. Chairman, I am Dr. Felix E. Demartini, executive director of Presbyterian Hospital in the City of New York at the Columbia-Presbyterian Medical Center. I appreciate the opportunity to submit testimony before this subcommittee.

Ours is an internationally-renowned tertiary care center nearing its 50th anniversary. This institution is responsible for innumerable medical advances that have benefited patients throughout the U.S. and indeed the world. My purpose in providing this testimony today is twofold: first, to endorse the concept that more rational classification of health care providers will greatly enhance the health care delivery system throughout the United States and second, to seek this subcommittee's understanding of the adverse financial implications this legislation will impose unless special provision is made for tertiary care centers. I refer particularly to the inadequacy of reimbursements from Medicaid and other third party payers.

Tertiary care provides treatment requiring a multi-disciplinary, highly technical scientific approach, which by its nature is investigational and advances the understanding of disease and the management of patients and which can only be accomplished in a tertiary care patient facility.

The tertiary care facility is one engaged simultaneously in clinical investigation, teaching activities and patient care. This patient care is care which residents, interns, fellows and supervising physicians render in connection with a graduate medical education program and in which patients require a substantially greater intensity of treatment.

Tertiary care is rendered in such areas as regionalized high-risk obstetrical and perinatal care, organ transplantation, open heart surgery, comprehensive cancer, joint replacement and reconstruction, pulmonary function care, comprehensive peripheral vascular care, regionalized ophthalmological care and surgical intensive care.

Tertiary care is costly. While the Presbyterian Hospital's expenses have risen on nearly all fronts, the losses due to inadequate reimbursement for tertiary care are especially vexing. It is noteworthy to mention here that more than three-quarters of our Hospital's income is now under restrictive government control. This control results in enormous government-mandated reimbursement losses which will approximate \$12.7 million this year. Presbyterian's total operating income for the nine months ended September 30, 1977 was \$97,915,000 while expenses totaled \$107,417,000, to create an operating loss to date of \$9,502,000. A substantial portion of this loss is directly attributable to tertiary care activities. Total operating expenses of the Hospital projected for 1977 amount to \$144,532,000, an increase of 6.2 per cent over 1976 and 307 per cent increase over the last decade.

Let me put the subject of tertiary care in more human terms. I would like to relate to you how our tertiary care effort is routinely saving lives. All of these lives would be lost in many places through the world.

Retinoblastoma is a malignant tumor of the eye's light-sensitive cells, which may affect one eye or both. The disease attacks very young children—usually under the age of five. Mothers and fathers first realize that something is wrong when they notice a cat's-eye reflex, a milky gleam, within the pupil of their child's eye.

Dr. Robert M. Ellsworth, Chief of our Ophthalmology Clinics, heads a team that has preserved the useful sight—as well as lives—of hundreds of children from the U.S. and all over the world.

These children visit the Hospital for a period of years for radiation, surgery and chemotherapy. An extra human touch for the children and their accompanying family members is provided by a special, cozy room to stay in at Reese House, a brownstone just a short walk from the Hospital.

This disease is 100 per cent fatal in Nigeria and 95 per cent fatal in the Philippines. At Presbyterian Hospital, the cure rate is 82 per cent. Further work is now being done which will help doctors find out what factors predispose

people to retinoblastoma and other cancers—and thus elevate the rate of successful treatments even further.

The youthful victims of retinoblastoma exemplify the types of patients whose lives are regularly being saved at tertiary care facilities. Unfortunately, for our Hospital, such programs are expensive and contribute to large recurring losses. During the past eight years, our Hospital's chronic under-reimbursement for such efforts has resulted in roughly a \$40 million erosion of capital reserves. At this time, these reserves stand at a perilous \$14 million. It is apparent to us that time is fast running out for our Hospital. We are facing difficult decisions in the coming months. Your help is urgently needed now in systematizing and reimbursing tertiary care efforts so that these essential programs can be maintained.

Blue Cross of New York records show that the Presbyterian Hospital in the City of New York has been more successful than any other comparable teaching facility in New York City in avoiding large increases in costs per patient admission by greatly reducing the average length of patient stay. Starting in 1975, with a length of 9.27 days, our Hospital has whittled away at that figure until it has now been reduced to 7.47 days for the first six months of 1977 for Blue Cross patients. Unfortunately, the net effect of this reduction in length of stay is a backlash of lost income, roughly \$12.7 million in 1977, on a base of already poor reimbursement rates.

It is a matter of irony that higher productivity (decreased length of stay) at Presbyterian Hospital has very little to do with greater income. We are, in fact, penalized for our productivity since some present government-mandated reimbursement formulas do not recognize or reward our Hospital for its efficiency.

The unrealistic Medicaid outpatient rates have a particularly harsh effect on the Hospital's vast clinic program. Ambulatory care can be summed up rather simply: Everybody's for it and nobody's paying for it. Nearly one-quarter of a million residents of upper Manhattan depend on the clinic and Presbyterian's ward services for medical care. It is distressing to realize that, although we are fulfilling our role as a voluntary hospital and meeting the needs of our neighbors, government seems unwilling to ease the financial burden we have assumed. This financial burden is, of course, especially onerous in the tertiary care areas. The Vanderbilt Clinic at Presbyterian Hospital, in providing millions of dollars in care for the indigent, will lose an estimated \$7 million this year.

Reimbursement problems arise when arbitrary ceilings—either federal or state—are applied to allowable hospital costs or revenues. The same sorts of problems also arise when methods of hospital classification are not capable of responding to changes in a given institution's case mix. In relying primarily in bed complement for classification purposes (and thus presumably for rate control purposes) the Talmadge Bill fails to allow for government-mandated regionalization of health care services. Regionalization concentrates steadily, increasing percentages of expensive services in a few hospitals, thus distorting the apparent cost effectiveness of these institutions. A short hypothetical example will suffice:

During the calendar year 1976 Hospital X operated on a breakeven basis and performed 1,000 hernia operations at an average cost per operation of \$1,000. During that same period, Hospital X performed 1,000 organ transplantations, open heart surgeries and total joint replacements at an average cost per operation of \$10,000. Total costs were thus:

1,000 cases times \$1,000-----	\$1,000,000
1,000 cases times \$10,000-----	10,000,000
Total costs (revenue)-----	11,000,000

During 1977 Hospital X responded to its local Health Systems Agency and agreed to become a regional center for organ transplantation, open heart surgery and total joint replacement. Two thousand such operations were done. The hernia operations were successfully accomplished at community hospitals at an average cost of \$800 apiece—savings to consumers of \$200,000. The 2,000 tertiary operations were accomplished at an average cost of \$8,000 apiece through economies of scale—savings to consumers of \$4,000,000 over the 1976 costs.

Comparing 1976 and 1977 costs at Hospital X:

Total 1976 costs-----	\$11,000,000
Total 1977 costs-----	\$16,000,000
Increase 1977 versus 1976 total costs (percent)-----	45
Decrease 1977 versus 1976 costs per tertiary care (percent)-----	20

Such increases in tertiary patient care account for a preponderance of the current operating losses at The Presbyterian Hospital in The City of New York.

I am proposing a plan today to deal with the inequities thrust upon tertiary care centers such as Presbyterian Hospital. It is evident that we must obtain relief quickly if we are to continue to be able to provide this essential, but costly care to our patients.

As a first step I believe that the subcommittee should convene a Tertiary Care Study Commission composed of representatives of Presbyterian, Duke University Medical Center, Methodist Hospital (Houston), University Hospital (Seattle), Barnes (St. Louis), and The Emory University Medical Center. This group of tertiary care centers should report to the Department of Health, Education and Welfare. The Commission would be charged with developing a national list of tertiary care centers and devising a formula for equitable tertiary care reimbursement.

This subcommittee should be represented as an ex officio member of the Study Commission. We look forward to working with the subcommittee to see to it that such a Commission is formed so that tertiary care can be rationalized, regionalized and reimbursed.

Time is running out for tertiary care centers. They have all been in the forefront of research, patient care and medical education. But in order for them to continue to provide national and international leadership in the delivery of quality health care, we must restore their financial health. Thank you.

THE KOLFF FOUNDATION,
Cleveland, Ohio, October 12, 1977.

FINANCE COMMITTEE,
U.S. Senate,
Dirksen Senate Office Building, Washington, D.C.
(Attention of J. Constantine).

GENTLEMEN: It has come to my attention that there will be hearings before the Senate Finance Committee on October 21st concerning House Bill 8423.

I had previously testified before the House Subcommittee which was considering House Bill 3112, which was the predecessor to H.B. 8423. Since the new bill contains quite significant changes from 3112, I would like the opportunity to present our views again, if possible.

I am appending a written statement which I hope will be informative as to the possible effect of the enactment of 8423.

Sincerely yours,

JOHN B. MOORE,
Executive Director.

Enclosure.

STATEMENT OF JOHN B. MOORE, EXECUTIVE DIRECTOR OF THE KOLFF FOUNDATION,
IN RE H.R. 8423.

The Kolff Foundation has been concerned with the welfare of home dialysis kidney patients since we inaugurated our program of low cost rental of artificial kidney machines for such patients in January 1969.

From our experience in dealing with home dialysis patients since that date, we feel that, since the enactment of H.R. 1 in July 1973, which covered nearly all E.S.R.D. patients under the Medicare-Social Security umbrella, there has been an increased use of hospital and center dialysis and a great fall-off in the number of kidney patients opting for home dialysis. While we do not believe that all patients not eligible for transplants should be on home dialysis, we do think that this modality is by far the best for a great number of kidney patients, especially if rehabilitation is a primary goal, and it also is the least expensive treatment presently in vogue.

Because of certain imbalances in the treatment of home dialysis patients under Medicare regulations created before the E.S.R.D. program came into being, The Kolff Foundation, in December 1973, presented to Medicare-Social Security our plan for a single billing for each dialysis treatment, which would cover the artificial kidney machine, its service, maintenance, any parts, reconditioning, storage when not in use, etc., and the one-time non disposable supplies, as well as the ancillary supplies needed for each treatment, by means of a single unit cost for each dialysis.

With the approval of Medicare-Social Security, we launched our program in July 1974 with seven home dialysis patients. At the present time, we have nearly 200 patients serving 10 states and 21 hospitals. The Kolff Foundation has not solicited the kidney facilities and has only entered into contracts with hospitals where we felt the program would be advantageous to the patients, first of all, and to simplify administration and minimize paper work, secondly.

Since The Kolff Foundation is a non profit organization, we do feel that our present charge of \$78 per dialysis can stand comparison with the Sidney Disease Institute program in New York State and the long term program for home patients administered by the Northwest Kidney Center, presently under the direction of Dr. Christopher Blagg.

We view S423 as a necessary enactment if the Government wishes to preserve the concept of home dialysis as a preferred treatment modality in partnership with transplants. The provisions of the bill which increase entitlement to Medicare coverage for both modalities, eliminating waiting periods and extending post transplant coverage, will be very helpful. Most of the other provisions of the bill are discretionary inasmuch as they depend largely on such regulations as the Secretary of Health, Education and Welfare deems essential to pursue the objectives set forth.

We have stated in our original testimony before the House Subcommittee on 3112, that we believe the selection of hospital dialysis, center dialysis, self care or home dialysis, and cadaver or live donor transplant does not depend on patient choice as a general rule, but is determined by the commitment of the facility to the particular method chosen. This is determined, in most cases, by the profit which may accrue to the facility in the case of center or hospital dialysis and by the surgical capabilities and range of objectives in the case of cadaver and live donor transplants.

We have also testified that increasing benefits to home patients, such as the use of dialysis aides, payments to dialysis partners, increasing mobility, could be very helpful. Removal of imbalances in payments to nephrologists between care of center and hospital patients, as against home patients, would have a good effect.

We are extremely hesitant to endorse a possible 70% cap based on in center cost as a method of cost containment without possible adjustment for cost escalation for a one year period.

Along with Congressman Vanik, we have contended that the choice of expensive dialysis machines and dialyzers was not medically essential for good patient care in many cases. We have also felt that physicians making these choices were impelled to do so by medical and product liability claims, which were possible if the best (read, most expensive) equipment were not chosen. Consequently, we have felt that attention to new insurance approaches would result in a large cost savings, not only in the E.S.R.D. program, but other medically related areas as well.

We have also indicated in our testimony that the proliferation of government agencies having voices and ill defined responsibilities in the E.S.R.D. program are an increasing source of confusion and greatly escalating costs and paper work.

We feel that very little attention is being paid to new techniques which are developing in the treatment of dialysis patients, such as wearable or portable dialysis machines, microbiology, ultrafiltration plus dialysis, and the like. These developments, if properly funded and not stymied by F.D.A., could change the whole picture of kidney dialysis treatments in the next few years and would greatly increase the number of people on home and self care dialysis, at a reduction in cost, which might exceed 25% of the \$12 million per week now being spent.

Finally, we appreciate the opportunity to give our views to the Finance Committee, with no claim to omniscience, but rather to present a layman's view based on nearly twelve years experience in dialysis, beginning with a very small part in the development of a washing machine kidney with Dr. Willem Kolff at the Cleveland Clinic.

STATEMENT OF JOHN F. HORTY, PRESIDENT OF THE NATIONAL COUNCIL
OF COMMUNITY HOSPITALS

My name is John F. Harty. I am President of the National Council of Community Hospitals, which represents the interests of America's community hospitals. I appreciate this opportunity to present NCHC's views on the staff's

outline of possible ways of expanding Senator Talmadge's proposal to reform the reimbursement system. I testified on S. 3205 last year and on S. 1470 and S. 1391 this June. I welcome this opportunity to supplement my testimony in light of the recent recommendations of this Committee's staff.

We have had only a short time to consider the staff's proposal, and that proposal is stated in broad outline. This statement, therefore, can do no more than highlight our major concerns. A more detailed statement will perhaps be appropriate if and when the staff's recommendation is committed to statutory language.

I would like to emphasize at the outset that we are gratified by the care and attention and knowledge that have gone into the staff's proposal, and the imaginative mechanisms that have been developed. As with the previous proposals, this effort reflects a conscientious and creative effort to develop new ways of paying hospitals for the services they perform. We wholeheartedly support that effort.

The Administration bill, on the other hand, does not even address the deficiencies in the reimbursement system; it would simply prohibit hospitals from receiving more than a certain amount of revenues. We commend Senator Talmadge and his staff for continuing their efforts to improve the reimbursement system, rather than simply putting limits on the amount of revenue hospitals can receive. We believe, indeed, that the major weakness in the Talmadge proposal is that they do not go far enough in reforming the reimbursement system.

Senator Talmadge's proposal essentially represents adjustments to the present reasonable cost system of reimbursement. They are externally and even arbitrarily imposed limitations on the operation of the reasonable cost scheme. However, we believe that the underlying structure of reasonable cost is itself fatally deficient. I outlined the reasons we believe reasonable cost should be scrapped in my testimony on S. 3205 in July 1976. Because of these considerations, NCCH believes it is futile to attempt to fix the reasonable cost system by constructing various additional excrescences upon it. Indeed, the effort to override the basic problems of reasonable cost by building ever more elaborate superstructures on that system contributes to the incredible complexities that are inherent in S. 3205.

The Administration's cost containment bill does not address any of the structural problems in the reimbursement system. The revenue limitations it would impose would penalize the efficient, growing hospital and benefit the inefficient, stagnant hospital. The Administration bill would be retroactive. It is fiendishly complex and would require a new bureaucracy (no doubt with ever increasing numbers of supergrade employees) to administer.

The Administration bill would, by providing a pass-through for increases in wages paid nonsupervisory employees, reduce hospital administrators' leverage to contain this major cost element. We find it ironic that the Administration recognizes that hospitals have been successful in restraining unwarranted wage increases, but because of hospitals' success, the Administration would curtail their power to continue that success.

On the other hand, the Administration would limit hospitals' revenues for other elements of their costs—even though they have far less ability to control those costs than wage costs. Indeed, it is not far fetched to suggest that hospital costs conceivably could increase as a result of the Administration's bill more than they would if the bill is not passed, since nonsupervisory wages could rise more than the bill would limit revenue increases for other hospital costs.

Finally, the Administration bill seems to be intended to be a permanent system for the future; Administration disclaimers that it is intended to be a temporary measure are becoming continually less insistent and indeed the Administration itself has made projections of the effects the bill would have after five years of operation.

The Administration's bill is a disaster—for patients and the hospitals that serve them, as well as for the Government, which will find itself ever more deeply involved in running a more chaotic, more expensive, and less effective system.

Because of these factors, as I mentioned in my testimony in June, NCCH developed its own proposal for cost containment. The main elements of this proposal (embodied in H.R. 8295) are a two-year moratorium on new capital expenditures (to apply to expenditures by everyone in the health care field, not only hospitals) and a freeze on increases in labor inputs per patient day. This

proposal would save approximately the same amount of money as the Administration claims for its bill. It would have a number of advantages: it would be free of the incredibly complex structure of the Administration bill; it would require no new bureaucracy to administer; it would preserve hospitals' managerial discretion; it would address the causes of hospital cost increases, rather than merely putting an artificial lid on the results; it would not be retroactive; it would be clearly temporary until long-range reforms could be implemented. I again urge you to consider its merits.

As I mentioned in my testimony in June, it is doubtful that S. 1470, as it then existed, could be implemented quickly enough to be an effective immediate cost control measure. I also pointed out that by building upon reasonable cost, the proposal was unlikely to have any significant cost containment effect.

I note that the most recent staff proposal suggests that the routine service revenue limitation be implemented more quickly than is proposed in S. 1470. However, the complexity of the classification scheme and of the wage and market-basket indexing in S. 1470 persuaded us that the proposal could not be implemented by 1979 or even 1981. We certainly do not believe it can be implemented, as the staff now would propose, by 1978, particularly since the staff's proposal would add the new complexity of applying the limit to revenues.

The proposal to apply the limit to revenues rather than costs introduces a host of additional complexities. For instance, can one determine without complex and arbitrary formulas the extent to which a particular item of revenue is attributable to one of the excepted items of cost? How does one determine how much revenue is attributable to wage costs and how much to other costs? What is the basis for gearing the revenue limit to 103 percent of cost? For instance, how would the bill deal with the fact that hospitals are not even being reimbursed for their full reasonable cost under Medicare and particularly Medicaid?

We note with particular concern the suggestion in the staff proposal that "certain costs unique to proprietary institutions" be excluded from the classification scheme envisaged by the proposal. We do not know what those costs are. Is profit a cost? If so, provision should also be made for non-profit hospitals to be allowed to earn a surplus of revenue over costs. If particular costs are to be excluded from the classification system, the costs which should be excluded are those which are borne disproportionately by community hospitals—for instance, costs incurred in serving Medicaid patients and providing free care.

The classification scheme envisaged by the routine revenue limitation is chimerical. Hospitals cannot be classified on any fair basis. And the proposal is inherently complex. The indexing data required for the scheme to work are not available, and likely will never be. Statisticians cannot—and should not—classify the inherent diversity of human institutions such as hospitals. The calculations contemplated by the revenue service limitation will be time consuming, complex, probably impossible, and in any event largely irrelevant to efficiency.

As we understand it, the staff now proposes that the classification/indexing system ultimately be applied even to ancillary services as well. This scheme is even more chimerical than the belief that hospitals can be fairly classified by routine costs. Ancillary services comprise the greatest difference between hospitals (which is one reason even routine costs cannot be classified accurately).

But we are particularly interested in the interim control mechanism suggested: a limit on increases in revenue from ancillary services per admission compared to a base year. This proposal is conceptually similar to our suggestion that there be a limitation on increases in a hospital's labor inputs and for that reason we believe it is a helpful step in the right direction. It comes closer to addressing the causes of revenue increases than does the Administration bill. But it still is not acceptable. There are numerous major drawbacks to the proposal as proposed:

1. Hospitals cannot control or determine the extent to which ancillary services are provided. Doctors make these decisions. Thus hospitals are not able to determine utilization of ancillary services as required to comply with a revenue limitation on ancillary services.

In his remarks before the Hospital Association of Pennsylvania in October, 1976, Senator Talmadge noted that hospitals do not have legal authority or the power to make the decisions that determine the cost of care because the medical staff decides admissions and length of stay, what tests are performed, and so on. Senator Talmadge continued at that time by saying that we "cannot continue to accept that reality as an excuse forever." We are disappointed that the staff apparently has taken him literally, and focused its cost containment proposal on an element of hospital services that hospitals cannot control. Instead of attempting to brush off the facts of hospital life, we suggest that cost containment

measures be formulated that are geared to items that hospitals can control—and the item of cost as to which they have clearly the most power to control is the number of employees employed.

2. To the extent that doctors' behavior might be affected by a limitation on hospitals' revenues, the proposed limitations could have undesired effects. The limitation on ancillary service revenues might encourage doctors to admit patients who need the least intensive care, those who require fewer ancillary services, in order to raise the permissible average for other patients who may need more intensive ancillary services. Yet the incentive should be to make these less sick patients out-patients, rather than in-patients.

3. The exception provided for ancillary services that are part of a capital expansion raises other problems. Such an exception, for instance, will only encourage expansion, whereas at least for a short term cost containment measure it would seem that expansion should be discouraged while the system is restructured. Also, would the exception apply to new equipment that replaces old? The demise of an old, depreciated X-ray machine and its replacement by a new, more expensive one would significantly affect the hospital's cost for that ancillary service, but would not be an expansion. Would the proposed exception apply in this circumstance? If it did not, a hospital might not be able to collect sufficient revenues to recoup the cost of needed new equipment.

4. The correlation between cost and revenue is elusive. The revenue for ancillary services is not a function merely of the cost of that service, but of a hospital's total revenue needs—including those caused by bad debts, free care and underages from Medicare/Medicaid reimbursement. Moreover, how are revenues for ancillary services to be divided into labor and nonlabor components? Is the Secretary going to make that allocation for every hospital? How are nursing costs, for instance, going to be allocated between routine and ancillary services? Moreover, if operating costs for ancillary services that are part of capital expansion are disregarded in computing the limitation, would permissible revenues for that service be unlimited?

5. The limit on ancillary service revenues will encourage physicians to increase the amount of medical equipment they purchase for their own office, and increase utilization of equipment presently owned by them. If a physician knows that a hospital will be prohibited, because of the revenue limitation, from receiving payment for an ancillary service, he will perform the test or procedure in his own office. The result will only be an increased decentralization of medical delivery and increased duplication of expensive technology.

NCCH believes, in sum, that the staff proposal merely adds to the complexities and the inherent weaknesses of S. 1470. We do, however, welcome the suggestion that operating revenues be limited by focusing on a hospital's own experience. We believe that labor intensity is a more appropriate criterion, and a limit on increases in employees per patient day is a simpler cost containment measure. We urge this Committee to consider that proposal.

STATEMENT OF ROBERT A. HAGGLUND, PRESIDENT, EMI MEDICAL, INC.

EMI Medical, Inc., the pioneer and leading manufacturer of computed tomography, appreciates the opportunity to submit testimony for the record on S. 1470 the "Medicare and Medicaid Administrative and Reimbursement Reform Act" and S. 1391 the "Hospital Cost Containment Act".

CT-scanning, a highly sophisticated diagnostic modality combines conventional x-ray with a computer. It has been hailed as the most significant breakthrough in diagnostics since Roentgen's invention of x-ray, nearly a century ago.

Computed tomography's rapid acceptance by the medical community and its high purchase cost has caused great concern to medical planners and government officials who ponder the appropriate role for this and other high cost technology within the health delivery system.

As the debate over rising costs in the health field has escalated, technology has been labeled a culprit by several factions. CT scanning has been singled out as the prime example. Lost has been all mention of the advances CT scanning has brought to the practice of medicine.

Some of the most painful and dangerous medical procedures such as radionuclide brain scans, cerebral angiography and pneumoencephalograms are being eliminated by use of this technology. Pain and suffering diminish while superior diagnostic data is provided to physicians.

Moreover, EMI Medical, Inc. contends that when appropriately employed CT scanning will reduce costs by eliminating surgeries, shorten or in many cases professional journals, documenting computed tomography's superior diagnostic tests.

Since CT technology is in its infancy, these assertions have been difficult to document. Within the next few months, however, clinical studies performed at Massachusetts General Hospital and the Mallinckrodt Institute will appear in professional journals, documenting computed tomograph's superior diagnostic capabilities and its cost effectiveness.

The Massachusetts General study conducted by Dr. Whittenberg states that 27 per cent of all surgeries were eliminated when CT body scans were employed. This has tremendous cost saving implications.

Further industry statistics reveal that dollars spent on diagnostic imaging machinery since the introduction of CT have only risen three per cent. Clearly, the old is being replaced by the new with little dollar effect at point of sale.

Under normal circumstances, medical technology is defended by providers and medical professionals. Since the announcement of the Administration's Hospital Cost Containment proposal, hospitals have been under attack for being "obese" and doctors for practicing "candy store" and "cadillac" medicine. Technology's normal advocates are in this instance too busy defending themselves.

Further, the Dept. of Health, Education and Welfare in championing the Administration's proposal has testified on several occasions that Southern California has enough scanners to service the nation's needs. This is a colorful way of citing the problem of rapid proliferation. HEW, however, is quick to note that the system needs more outpatient servicing, less hospitalization and faster diagnoses. EMI believes computed tomography holds the key for accomplishing these goals.

In a recent study of abdominal mass, pelvic mass and obstructive jaundice, EMI established that computed tomography used in the diagnostic flow would create cost savings of better than \$1 billion nationwide through decreased hospitalization, testing and the like. That study is available for public and professional scrutiny.

Government, in seeking greater cost savings, should encourage progress that has built-in cost effectiveness. It must encourage the private sector, not dismantle it.

Computed tomography, unfortunately, has become a political football over which the debate on high cost technology is being waged. Lost is the affirmation of this technology's superior capabilities and its potential for improving the quality of care delivered, as well as more efficient utilization and increased cost savings.

The advent of medicare/medicaid caused an explosion in the nation's health system. With this rapid growth has come tremendous progress.

Several types of cancer, heart disease and other killers are on the decline. This is a direct result of a national effort.

This progress has come at tremendous expense. And we at EMI commend the Administration for focusing attention on this situation.

We don't believe, however, that S. 1391 is the proper solution.

Cost containment in capital investment should be predicated on cost-effectiveness. Superior technology should be allowed to replace the inferior.

We believe that not enough emphasis has been given to medical need. S. 1470 will encourage providers, doctors and patients to utilize outpatient facilities more economically and place emphasis on the cost effectiveness of diagnostic and treatment methods.

EMI endorses this approach.

Of concern to EMI is S. 1391 and the detrimental impact of Title II "Moratorium on Acquisition of HEW Health Care Equipment and Facilities."

This section calls for a moratorium on hospital capital expenditures of \$150,000 or more unless expressly exempted.

The exemption process calls for a state health planning and development agency designated pursuant to Section 1521 of the National Health Planning and Resources Act of 1976; a certificate of need program satisfactory to the Secretary pursuant to an agreement with the Secretary under Section 1122 of the Social Security Act; and a state medical facilities plan satisfactory to the Secretary under Section 1603 (a).

Since no state is presently able to meet such requirements, a de facto moratorium is in place under Title II, S. 1391.

A moratorium is more than a brief hiatus.

EMI questions whether those envisioning a moratorium as long as two years realize that such action would force total dismantling of manufacturing concerns and result in the loss of a generation of progress; a drying up of venture capital in the medical technology area; and a withdrawal of manufacturers from the medical products sector.

If a moratorium is enacted, then the present tools available to physicians become locked in the system. The medical practitioner, unfamiliar with the more superior technology, will not incorporate these advances in daily practice and improvements in diagnosis and patient handling will suffer.

CT scanning is such a superior diagnostic tool. At present, many physicians employ it only after having received insufficient data from other tests. As they become more familiar with CT, they will employ its capabilities earlier in the diagnostic flow. This way tests, hospitalization and in a high percentage of cases, surgery will be eliminated, resulting in improved health care at substantial cost savings. But without access how can there be programs?

EMI questions not only a moratorium on equipment and facilities but also the \$2.5 billion capital expenditure proposal as initially put forth by HEW. The Department claims this will reduce capital spending more than 50 percent in the first year. Does this mean capital expenditures in 1977 were \$5 billion? We seriously doubt such a figure. Creditable sources place the figure closer to \$8 billion. Further since no formula was in place for last year's total, how can HEW reduce this figure by a half.

HEW proposes rationing of certificates of need to States on a population basis, with final authority resting in the Secretary's hand. This is contrary to the Planning Law which calls for decisions at the local level.

What will happen to that community HSA which in reviewing proposals turns down a high percentage and then finds its approved capital expenditure vetoed by the bureaucracy? That HSA will come under tremendous pressure from the local community and the people will feel the heavy hand of government once more. This runs contrary to public desires and to the Administration's expressed goal of decision making at the local level.

If the American people were asked their priorities, EMI is confident that health would rank with defense. If they were told that the health industry's capital expenditures were to be slashed at a minimum of fifty percent, we feel they would be incensed.

We believe the American people want cost containment but do not want to sacrifice their present high standard of health care. We feel technology holds the key to achieving both these goals.

Title II as presented is not the answer.

The Health Planning Law is the in-place vehicle to insure proper allocation of community resources. HEW, working with all components of the health delivery system, should lead the way in educating HSA's as to the reality of costs and quality in the health sector. Give decision making on the local level a chance.

We find it ironic that the Administration can identify third party cost reimbursement which has both patients and providers straining the system, lack of competition in several areas and lack of incentives as the prime reasons for spiraling health costs and then present to the Congress the Cost Containment Act which doesn't address these areas.

Artificial and arbitrary percentage cuts don't address the problem. They cripple the system. One which admittedly at a substantial price has made tremendous progress.

EMI applauds the Administration for seeking a solution to this pressing national problem.

S. 1470, properly written, will bring discipline to medical markets and appears a more substantive approach.

STATEMENT BY L. T. WILBURN, JR., PRESIDENT AND BARRY D. BROOKS, VICE PRESIDENT OF FINANCE, OF BETHESDA HOSPITAL AND DEACONESS ASSOCIATION, CINCINNATI, OHIO

Bethesda Hospital and Deaconess Association ("Bethesda") operates a total of 630 acute care hospital beds on two sites in the Greater Cincinnati area, one site, a 480 bed facility and the other, a 150 bed facility. The occupancy for the smaller facility has averaged 99 percent over the past three years while the

larger facility has operated at a 93 percent occupancy rate for its medical surgical beds during the same three-year period. Bethesda is currently in the midst of an approved expansion and renovation project to expand its facilities housing ancillary services for both inpatient and ambulatory care patients, increase its total bed capacity to 730 beds and construct a freestanding outpatient surgery center. A summary fact sheet on Bethesda's utilization and efficiency is attached as Exhibit A.

Bethesda feels it is unfair to control the revenue of a single industry when that industry has no control over the majority of costs it must incur to provide its normal services. Any such controls will limit the effectiveness of the health care industry, result in a decrease in quality of service and severely restrict the industry's ability to attract qualified personnel. If any restrictions are to be imposed, they should be ones which recognize the uniqueness of the industry and attempt to promote efficient management and the rendering of services.

Our remaining comments are divided into two distinct parts. The first part sets forth our comments concerning the proposals contained in the release entitled "An Alternative Approach to Hospital Cost Containment." The second part contains our concerns with the cost containment proposal supported by the Administration, specifically as set forth in the House counterpart to S. 1391.

I. COMMENTS REGARDING THE PROPOSALS CONTAINED IN THE RELEASE ENTITLED "AN ALTERNATIVE APPROACH TO HOSPITAL COST CONTAINMENT" AS PROPOSED BY SENATOR TALMADGE.

Since we do not have a copy of an actual Bill, our comments are based upon a review of the statements made in the release entitled "An Alternative Approach to Hospital Cost Containment," (the "Release"). Because of this, many, if not all, of our concerns may be solved by the actual wording of a Bill.

We applaud the effort spent in attempting to develop a more sensible proposal than that supported by the Administration. If certain changes are made and some points are clarified, we believe this legislation may be acceptable if some legislation must be passed.

Our comments are:

1. Since the program is based on many untried and unproven concepts, we recommend the program be implemented for a limited period of time and suggest three (3) years.

2. The Release seems to use revenue and costs interchangeably. It does not recognize that many hospitals receive a majority or high percentage of their revenue from prospectively negotiated charges. These hospitals would be especially penalized because a system which is based on costs does not recognize all costs of doing business. It overlooks such costs as bad debt expense, charity and other deductions from revenue. We suggest that controls be applied on the basis of net revenue (gross revenue less deductions for bad debts, contractual adjustments, charity and such other deductions as are appropriate under generally accepted accounting principles). One way to accomplish this is to control routine service revenue and ancillary service revenue on the basis of gross revenue per day and per admission, respectively, and then consider deductions from revenue when the two revenues are combined for testing compliance as indicated in the Release. This method would prevent the Bill from creating any inequities due to not recognizing deductions from revenue and the effect of such deductions on total revenues actually received by a hospital. The information necessary to test on this basis is available from the Medicare Cost Report. This method would treat all payers equally and all hospitals equally.

Failure to recognize these deductions could result in hospitals being required to pay back revenues they did not realize in cash.

Example: A hospital in the year prior to controls had gross revenue of \$1,000,000, deductions from revenue of \$100,000, resulting in \$900,000, in cash realized from the charges rendered. Assume in the first control year that hospital had total allowable revenue of \$1,000,000, actual gross revenue of \$1,100,000 and that deductions from gross revenue as a result of bad debts increased to \$200,000 resulting in the hospital receiving cash that year of \$900,000. If the legislation does not make provision for deductions from revenue, this hospital would be required to pay an excise tax of \$100,000 on revenues it was not able to collect.

3. Page 2, Paragraph 2, of the Release states that "the routine service revenue limit for a hospital whose annual accounting period begins on or after July 1,

1978 . . . would be equal to 120 percent of the average estimated routine service cost for the July, 1978-June, 1979 period for the hospitals in its group." In the previous bill proposed by Senator Talmadge, hospitals whose actual cost exceeded their payment rate by less than 20 percent (average per diem routine operating cost within the group) would be paid their actual cost. It is important to note that because of the relationship between cost and charges created by the Medicare definition of cost, these same hospitals may not be penalized under the provisions of the Release.

We believe there are hospitals in the country that could actually receive incentive payments from Medicare and Medicaid under this program and not be able to recover all the revenue they are now receiving from private payers. This occurs because of the mathematical relationship between gross revenue and deductions from revenue resulting from "cost" payers paying less than the full cost of medical service. A portion of such full cost of care is, therefore, passed on to other payers. Contractual adjustments (deductions from revenue) with cost payers are in effect discounts forced on a provider because of "volume purchases." Applying controls based on net revenue, as suggested in comment number two would eliminate this problem.

4. The Release indicates on Page 2, Paragraph 4 that the Secretary could construct wage level indices and could, by appropriate sampling, keep such data reasonably current. We believe such indices are desirable and that the Secretary should be required to develop the indices and keep them reasonably current.

5. On Page 3, Section 2, "Limitations on Revenue for Ancillary Services," the Release indicates the proposal would adopt, "on an interim basis the Administration's general approach to setting limitations on ancillary service revenue." We believe this interim period should not exceed two years.

6. On Page 3, Section 2b, ancillary service revenue is updated to the next accounting year by adding 103 percent of the increase in cost of the ancillary service experienced by a particular hospital between the two years. The Release further indicates this method is to be used for years after the base year because revenue data will not be available and cost increases will, therefore, be used as a "proxy." We object to this method of updating for two reasons:

a. There is no need for cost to serve as a "proxy" because both the revenue and cost data will be available on the Medicare cost report of each hospital in the base year and in all subsequent years. (See Exhibit B which is Worksheet C of the Social Security Administration's form SSA-2552. This exhibit is from Bethesda's Medicare Cost Report.)

b. Secondly, because of resulting deductions from revenue, if cost is used as the basis to update either routine or ancillary service revenue from the base or subsequent years, an increase in revenue of 103 percent of increased cost is insufficient to provide enough cash to pay for increased expenses and provide adequate working capital.

Example: Using the basic numbers in the example on Page 4 of the Release, assume the hospital's average gross revenue per admission in the base year is \$600. Assume further that its deductions from revenue are 10 percent of gross revenue or \$60. The hospital, thus, would realize cash of \$540 (\$600-\$60). Assume further in the base year that expenses amounted to \$540.

In the next accounting year the cost of providing these services increased \$60 so that 103 percent of this amount, \$61.80, should be added to the \$600; thus, the hospital's cash position from ancillary service revenue would be as follows: revenue per admission, \$661.80; deductions from revenue, \$66.18 ($\661.80×10 percent), realized cash, \$595.62 ($\$661.80 - \66.18). Expenses would be \$600 ($\$540 + \60), thus, resulting in a cash flow deficit of \$4.38 ($\$595.62 - \600.00) per admission from ancillary service revenue. This example ignores increased working capital required as a result of increased cost (such increased working capital costs would include increased inventory and accounts receivable costs resulting from inflation).

If cost is to be used as a basis for update, the percentage should include a component which recognizes realistic deductions from revenue as well as a component which provides for realistic working capital needs.

Statistics published by The American Hospital Association indicate that deductions from revenue for hospitals vary depending on the bed size of the hospital. The average for all hospitals is as follows for the three months ended May 31, 1977:

Deductions from revenue as a percent of gross revenue

Hospital bed size:	Percent
Under 50-----	6. 83
50 to 74-----	7. 39
75 to 99-----	7. 68
100 to 149-----	8. 71
150 to 199-----	10. 89
200 to 299-----	10. 77
300 to 399-----	10. 81
Over 400-----	11. 22

These statistics are provided to demonstrate both the variance and magnitude of deductions from revenue. Applying controls on the basis of net revenue rather than cost, as suggested in comment number two above, would eliminate this problem and would adequately provide for deductions from revenue.

7. The Secretary should be required, in developing the "market basket", to include a factor which adequately provides for deductions from revenue and for working capital requirements. Without such provision, this market basket approach has the same defect that exists by updating using 103 percent of cost as discussed in comment number six. Again, applying controls based on net revenue, as suggested in comment number two, would eliminate this problem and would adequately provide for deductions from revenue.

8. On Page 4, the second full paragraph of the Release indicates that "appropriate provisions" for exemptions would be made to adjust for the atypical cost and revenue patterns of newly-opened hospitals. We believe this provision should also include hospitals which, with planning approval, have increased their bed complement or had other significant change in capacity.

9. The Release indicates near the bottom of Page 5 that adjustments would be made to the ancillary revenue limit to accommodate approved expansion of patient care services and that "operating cost directly associated with capital expansion would be disregarded . . ." We believe it should be made clear that the capital cost as well as the operating cost associated with approved capital expansions in the ancillary area should be disregarded. The updating mechanism, as described in the Release, does not allow a hospital to be reimbursed for either operating or capital cost of a newly approved expansion of patient care services which are not in the base year or the first year after the base year.

10. We further believe adjustments to the ancillary revenue limit should include any project that received approval of the health planning agency prior to the base year but which was not implemented until after the base year. As previously indicated, the updating mechanism does not provide for either capital cost or operating cost of these new patient services. We believe the intention of this section is to include both future projects and projects which have been approved and implemented after the base year and only point this out for clarification.

11. The Release indicates allowable ancillary revenue per admission would be 50 percent for all admissions above 102 percent of the previous years. We believe the Bill should provide an exemption for a period of two years in the event additional beds are added pursuant to health planning approval. This two-year period should allow the hospital's admission base to stabilize after the opening of new beds.

II. COMMENTS IN REGARD TO THE COST CONTAINMENT PROPOSAL SUPPORTED BY THE ADMINISTRATION AS SET FORTH IN H.R. 6375, THE HOUSE VERSION WHICH IS SIMILAR TO S.1391

We believe the Administration's proposal is a completely unworkable solution and if enacted will cause a decrease in the quality of health care. Our primary objections are as follows:

1. The base year is arbitrary and the provisions for updating are inadequate to allow a number of hospitals to recover costs that they have already incurred although such costs were not incurred during the base year. Also, hospitals which have fiscal years ending in January of 1976 would be penalized by 11 months as opposed to hospitals whose similar fiscal year ended on December 31, 1975. The base year for a hospital such as Bethesda is the year ended January 3, 1976, 21 months ago. We believe the base year should be as current as possible so as to

avoid retroactively applying legislation such as this. Also, a hospital's own fiscal year should be used to avoid unfairness to certain hospitals created by an arbitrarily created base year. Restrictive legislation such as this should not be enacted retroactively so as to create further inequities amongst the covered hospitals.

2. The Administration's proposals would not allow hospitals to recover costs incurred as a result of capital expenditures for which commitments have been made and which have previously been approved by appropriate health planning authorities. This result is a capricious limitation on those hospitals which have previously made their plans and incurred commitments in accordance with the applicable law.

3. The admission load formula assumes a marginal cost factor of 50 percent on increased admissions. While we acknowledge that the marginal cost concept has some merit where there are only marginal admission increases, we do not believe it is applicable for a hospital which has had significant increases in demand or has had to change its capacity in order to meet demand. Significant inpatient admission increases create disproportionate increases in labor costs and the costs of ancillary services. Universal application of the admission load formula unduly penalizes those hospitals located in areas with rapidly increasing population.

4. The Administration's proposal fails to recognize that many of the costs incurred by hospitals cannot be controlled by management. Some examples are the much publicized increased cost of malpractice insurance, increases in energy costs, and costs incurred as a result of regulation, legislation or judicial action, such as increased costs associated with social security taxes, providing sick leave in lieu of maternity leave, increases in the minimum wage and increases resulting from the recently issued regulations regarding the handicapped.

5. Separately applying the controls to each cost payer and charge payers as a class will make it difficult for hospitals and the payers to administer a control program because of difficulties in identifying revenues from a joint sponsored admission and retroactive denial of payment relating to an earlier admission. The separate application causes conflict between the cash basis concept of revenue received and the accrual concept of charges imposed, especially when there is a change in patient mix. Thus, where the total number of patients remains the same but the composition shifts from patients covered by charge payers to patients covered by cost payers, a hospital's revenue limits would be decreased although it continued to have to treat the same number of patients. This is an unfair and irrational result. Also, an increase in the number of charity patients or bad debts would subject a hospital to penalties for revenues it never received.

6. The exception process contemplated by the Administration requires near bankruptcy as a precondition to relief and severely limits the number of situations in which an exception might be granted. We do not believe Congress can foresee all the hardships that may arise and should not legislatively restrict the Secretary's capacity to grant exceptions when needed.

7. The mandatory pass through of non-supervisory wages effectively removes approximately 50 percent of the hospital's cost of providing health care from the controls and we believe makes a mockery of the legislation itself. Additionally, this concept is bound to create additional labor relation problems for management without any corresponding benefit to all employees.

8. If non-supervisory wages are to be passed through, there should also be a pass through of the fringe benefits associated with such wages.

9. The Administration's proposal does not deal with costs associated with capital expenditures which are approved by appropriate health planning authorities. If health planning on a regional basis has any merit, then a hospital should not be restricted in recovering the costs to be incurred as a result of an approved capital expenditure. The exception process as proposed is not flexible enough to permit recovery of these costs.

10. The Administration's proposals are allegedly "transitional" but have no defined duration. Any such program should have no more than an extremely limited life and only until a more reasoned program can be developed.

In conclusion, we believe the Administration's proposals to be inequitable, unfair, arbitrary and unworkable. Bethesda Hospital is an efficient hospital and like other efficient hospitals would be unfairly penalized by the enactment of these proposals.

[EXHIBIT A]

BETHESDA HOSPITALS, CINCINNATI, OHIO

FACT SHEET

1. Medical cost in Cincinnati is lower than any other major urban area in the United States.
2. Bethesda cost per day is lower than any other major hospital in Cincinnati area.
3. Bethesda cost per admission is lower than all area hospitals except one.
4. Bethesda uses 2.45 Full Time Equivalents per patient day as compared to a national average of 3.12. (22 percent less)
5. Bethesda average collection period is 46 days compared to national average of 59 days. (22 percent less)
6. Bethesda detailed comparison to other hospitals nationally—see attached HAS statistics.
7. Bethesda detailed comparison to engineered standards—see attached OHMS statistics.
8. Medical/Surgical Percent of Occupancy :

Bethesda Hospital Oak :

1975 -----	94.2
1976 -----	91.7
1977 through September -----	94.6

Bethesda Hospital North :

1975 -----	98.3
1976 -----	98.5
1977 through September -----	100.5

OHMS AND HAS PRODUCTIVITY INDICATORS—BETHESDA HOSPITAL, CINCINNATI, OHIO, JULY, 1977
COMPARISON OF H.A.S. STATISTICS

Parameter	July-December, 1975			January-June, 1976			July-December, 1976		
	Bethesda actual	National median	Bethesda's comparative position	Bethesda actual	National median	Bethesda's comparative position	Bethesda actual	National median	Bethesda's comparative position
Nursing related:									
M/S man-hours PPD, Oak.....	4.55	5.86	1 5	4.02	5.58	1 5	4.78	6.13	1 5
M/S man-hours PPD, North.....	4.37	6.32	1 5	4.31	6.11	1 5	4.42	6.78	1 5
L. & D. man-hours/delivery.....	20.17	20.95	(2)	18.19	22.77	(2)	18.27	21.47	(2)
M. & S. expense, percent.....	15.05	18.90	1 5	14.00	18.40	1 5	14.50	18.50	1 5
ICCU man-hours PPD.....	17.53	17.86	(2)	15.06	16.70	(2)	20.00	18.80	(2)
Man-hours/OR visit.....	10.28	11.78	1 5	9.68	11.27	(2)	10.50	12.17	1 5
Laboratory:									
Laboratory expense, percent.....	4.40	6.90	1 5	4.20	6.90	1 5	4.10	6.80	1 5
Weighted-units/man-hour.....	67.00	43.30	1 5	68.34	45.69	1 5	23.09	41.76	1 5
Radiology									
Direct expense/procedure, Oak.....	11.42	10.81	(2)	10.76	10.92	(2)	12.55	12.03	(2)
Man-hours/procedure, Oak.....	1.14	1.29	(2)	.98	1.25	1 5	1.13	1.36	(2)
Direct expense/procedure, North.....	6.87	8.60	1 5	7.81	8.68	(2)	9.47	9.47	(2)
Man-hours/procedure, North.....	.83	1.05	1 5	.77	1.01	1 5	.82	1.11	1 5
Paramedical services:									
Respiratory therapy expense, percent.....	.75	1.20	1 25	.80	1.20	1 25	.70	1.20	1 5
Physical therapy expense, percent.....	.30	.60	1 25	.40	.60	1 25	.40	.60	1 25
Physical therapy treatments/Man-hour.....	2.15	1.30	1 5	2.05	1.37	1 25	1.53	1.25	(2)
Social service expense, percent.....	2.20	1.20	(2)	.20	.20	(2)	.20	.20	(2)
Medical record expense, percent.....	1.05	1.10	(2)	1.00	1.10	(2)	1.10	1.10	(2)
Other patient services expenses, percent.....	1.70	1.80	(2)	1.70	1.80	(2)	1.90	1.90	(2)
Corporate services:									
Meals served/man-hour.....	3.41	3.43	(2)	3.78	3.66	(2)	3.46	3.46	(2)
Housekeeping hours/1,000 ft. ²	28.16	42.09	1 25	29.62	41.11	1 25	30.31	41.14	1 5
Laundry pounds/man-hour.....	60.38	46.42	1 25	60.21	49.08	1 25	51.57	46.80	(2)
Fiscal services:									
Administration, man-hours/bed.....	18.79	16.11	(2)	18.94	16.09	(2)	17.93	16.10	(2)
Fiscal services, man-hours/bed.....	29.42	32.67	(2)	19.43	31.84	(2)	31.06	32.67	(2)

¹ Top (percent).

² Midrange.

OHMS PERFORMANCE INDICATORS

Department, indicator, and hospital	1976 periods 1-13			1977 records 1-5		
	OHMS standard	Bethesda actual	Performance rating, percent	OHMS standard	Bethesda actual	Performance rating, percent
Diagnostic radiology—Worked, hours per examination:						
Oak.....	1.00	0.92	109	1.00	0.98	102
North.....	.73	.75	97	.72	.74	98
Nuclear medicine—Worked, hours per examination:						
Oak.....	1.81	1.26	144	1.81	1.23	148
North.....	1.80	1.54	117	1.8	1.53	118
X-Ray therapy—Worked, hours per treatment: Oak.....	.73	.85	85	.73	1.00	74
Respiratory therapy—Worked, hours per treatment:						
Oak.....	.51	.64	80	.51	.62	83
North.....	.49	.71	70	.49	.63	77
Physical therapy—Worked, hours per treatment:						
Oak.....	.54	.61	92	.54	.57	96
North.....	.50	.46	110	.50	.44	114
Laboratory—Worked, hours per pro- cedure: Oak and North combined...	.27	.22	122	.27	.22	123
Fiscal services—Total worked hours...	157,382	151,086	104	61,880	61,259	102
Pharmacy services—Worked hours/ unit dose:						
Oak.....	.026	.025	103	.026	.024	109
North.....	.024	.026	90	.024	.025	90
Combined.....	.025	.025	100	.025	.024	105
M/S nursing—Worked hours PPD:						
Oak.....	3.88	3.81	102	3.88	3.65	105
North.....	3.66	3.83	96	3.66	3.77	97
All nursing (worked hours):						
Oak.....	1,050,965	1,078,771	97	425,589	433,281	93
North.....	330,307	353,239	94	118,161	132,156	83

Note: OHMS (Ohio Hospital Management Services) is an outside agency which sets normative standards for participating hospitals, therefore, OHMS performance statistics are measured against the concept of what "should be" rather than against other hospital averages.

EXHIBIT B

WORKSHEET C—DEPARTMENTAL COST DISTRIBUTION, PROVIDER NO. 36-0179

[Period: From Jan. 4, 1976, to Jan. 1, 1977]

Cost Center	Total	Ratio of cost to charges	Inpatient			Outpatient				Home Health agency
			Hospital	Subpro- vider I	Subpro- vider II	Skilled nursing facility	Title XVIII pt. B	Kidney acquisition	All other outpatient	
1 Ancillary service.....	\$3,205,098		\$2,983,553	0	0	0	\$16,796	0	\$204,749	0
2 Operating room.....	4,023,503	\$0.7966	3,745,387	0	0	0	21,085	0	257,031	0
3 Recovery room.....	0	0	0	0	0	0	0	0	0	0
4 Delivery and labor room.....	1,222,346		1,222,345	0	0	0	0	0	0	0
	1,811,454	.6748	1,811,454	0	0	0	0	0	0	0
5 Anesthesiology.....	0	0	0	0	0	0	0	0	0	0
	2,945,473		1,822,496	0	0	0	131,572	0	991,405	0
6 Radiology—Diagnostic.....	4,257,674	.6918	2,634,414	0	0	0	190,187	0	1,433,073	0
7 Radiology—Therapeutic.....	0	0	0	0	0	0	0	0	0	0
8 Radioisotope.....	0	0	0	0	0	0	0	0	0	0
	2,196,286		1,910,238	0	0	0	21,868	0	264,180	0
9 Laboratory.....	2,681,127	.8192	2,331,933	0	0	0	26,695	0	322,499	0
	0	0	0	0	0	0	0	0	0	0
10 Blood.....	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
11 Blood store, process, administrative.....	0	0	0	0	0	0	0	0	0	0
12 Intravenous therapy.....	0	0	0	0	0	0	0	0	0	0
	487,377		481,105	0	0	0	230	0	6,042	0
13 Oxygen (inhal) therapy.....	841,520	.5792	830,691	0	0	0	397	0	10,432	0
	492,297		306,434	0	0	0	18,758	0	170,104	0
14 Physical therapy.....	600,901	.8243	371,770	0	0	0	22,758	0	206,373	0
	0	0	0	0	0	0	0	0	0	0
15 Occupational therapy.....	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
16 Speech pathology.....	0	0	0	0	0	0	0	0	0	0
	414,346		306,653	0	0	0	9,432	0	98,261	0

See footnotes at end of table.

EXHIBIT B—Continued
WORKSHEET C—DEPARTMENTAL COST DISTRIBUTION, PROVIDER NO. 36-0179—Continued
[Period: From Jan. 4, 1976, to Jan. 1, 1977]

Cost Center	Total	Ratio of cost to charges	Inpatient				Outpatient			Home Health agency
			Hospital	Subpro-vider I	Subpro-vider II	Skilled nursing facility	Title XVIII pt. B	Kidney acquisition	All other outpatient	
	1	2	3	4	5	6	7	8	9	10
17 Electrocardiology	812,900	0.5097	601,618	0	0	0	18,505	0	192,777	0
18 SDTM	427,253		368,306	0	0	0	6,895	0	52,051	0
	397,642	1.0745	343,781	0	0	0	6,417	0	48,444	0
19 Medical supplies charged patient	1,450,916		1,391,133	0	0	0	6,794	0	52,988	0
	1,357,346	1.0689	1,301,419	0	0	0	6,356	0	49,571	0
20 Drugs charged patients	1,571,819		1,509,690	0	0	0	4,212	0	57,917	0
	1,945,266	.8080	1,868,376	0	0	0	5,213	0	71,677	0
21 Renal dialysis	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
22	0	0	0	0	0	9	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
23	0	0	0	0	0	0	0	0	0	0
24 Outpatient service	203,322		0	0	0	0	0	0	0	0
25 Clinic OB	1	-2,836.8234	0	0	0	0	0	0	-2,837	0
	1,167,643		83,978	0	0	0	65,476	0	1,018,159	0
26 Emergency	2,069,891	.5641	148,868	0	0	0	116,070	0	1,804,953	0
	28,881		0	0	0	0	0	0	28,881	0
27 Oncology clinic	13,930	2.0733	0	0	0	0	0	0	13,930	0
	0		0	0	0	0	0	0	0	0
28 Home health agency	15,816,055	0	112,385,933	0	0	0	282,034	0	2,941,931	0
29 Total	20,813,155		15,983,711	0	0	0	413,683	0	4,410,761	0

¹ Total inpatient ancillary service cost.

² Total inpatient ancillary service revenue.

ALLENTOWN AND SACRED HEART HOSPITAL CENTER,
Allentown, Pa., October 17, 1977.

MR. MICHAEL STERN,
Staff Director, Committee on Finance, Washington, D.C.

DEAR MR. STERN: Please accept this written comment for the Senate Finance Subcommittee on Health in their deliberations concerning the Hospital Cost Containment Act and the revised Talmadge proposal.

I appreciate the opportunity to respond to congressional efforts to provide an equitable solution to the health care problem.

(1) The Cost Containment Act treats all hospitals similarly, yet experience has proven that hospitals differ in their ability to deliver patient care cost effectively. A 9 percent limit will reward the inefficient hospitals and penalize those which have made an effective effort to reduce costs.

(2) The pass through of non-supervisory wage increases (an average of 90 percent of total employees) will make it impossible to contain employee wage and benefit costs. This pass through provision interferes with the normal collective bargaining process.

(3) By not controlling the prices of goods and services purchased by hospitals, the proposed 9 percent ceiling will become the minimum increase from vendors and suppliers over which the hospitals have no control. Many groups of hospitals are presently utilizing shared purchase arrangements to contain costs so hospitals are doing about as much as they can in this area.

(4) The exception criteria are so difficult that few hospitals would be able to meet financial hardship tests and obtain relief before serious erosion of their capital occurred. This criteria actually gives an advantage to the presently inefficient hospitals who may be achieving these criteria as a result of their inefficiency.

(5) The crucial role played by physicians in determining hospital costs/revenues is completely ignored. The physicians are the real consumers of health care. To impose revenue controls and tax penalties on hospitals when admitting practices and medical services are clearly under the physicians control and beyond the control of hospital Boards is grossly inequitable.

(6) Local HSA's or State agencies by and large are not able to assimilate the tasks that would be created by the Cost Containment Act. Training and funding is woefully inadequate. The proper implementation of this Act would be a long time off and will cause much bewilderment and harm at the state and local levels.

(7) The size and complexity of the health care industry deserves more than the imposition of a severe "transitional" program with many flaws and inconsistencies. It is unrealistic and unreasonable to expect most hospitals to comply with an abrupt curtailment of revenues within one year. The statistics widely used indicating that health care's rate of inflation is double that of the general economy do not take into account the unique nature of the cost increase factor in health care—particularly the intensity of service factor. The intensity of service factor represents more and better services (getting back to the doctor being the real consumer) given to a patient (or to the patient population) this year than in the prior year. PSRO's and Utilization Review are effective mechanisms to examine and determine appropriate levels of care and should be allowed to perform their intended mission.

A further comment on the comparison of health care's rate of inflation to the overall Consumer Price Index is appropriate. It is grossly misleading to compare the increase in hospital daily service charges with the increase in the Consumer Price Index as a whole. When those expenses attributable to hospitals are pulled out of the overall CPI for an accurate comparison, in 1976, the health care inflation factor was 7.44 percent (as opposed to the 15 percent + quoted by HEW) and the CPI factor was 5.60 percent. This is only a 33 percent differential as opposed to the 250 percent quoted by HEW. Since the service component of hospitals (salaries and wages) continues to be a high proportion of health care expenses, hospital inflationary increases will always be somewhat higher and this has to be a major consideration in adopting any ceiling. Any legislation must consider equitable control, not merely a control which lumps numbers for the benefit of emotional considerations. Please see the chart below for a clear understanding of this concept.

	Hospital		CPI inflation factor, percent
	Relative importance	Inflation factor, percent	
Salaries and wages.....	0.4215	3.54	0
Employee benefits.....	.0683	.73	0.32
Contracted services.....	.1056	.86	1.07
Supplies.....	.1606	.53	1.31
Interest.....	.0381	(.03)	(.03)
Insurance.....	.0252	.61	.53
Taxes and fees.....	.0017	.01	.12
Utilities.....	.0217	.19	.43
Miscellaneous.....	.0402	.24	.94
Capital expenditures.....	.1171	.76	.91
Total.....		7.44	5.60

(8) It would appear that superimposing a "transitional" national program on the well thought out programs already implemented will be counterproductive and further complicate the problem and possibly retard the effectiveness of current programs.

Obviously, only criticizing a program is a negative approach. In this regard, I offer some positive suggestions for change which I hope will provide help in the deliberations.

1. A program should be phased-in over a reasonable period of time. As a guideline, consider the experience of Johns Hopkins University Hospital, which successfully gradually reduced its rate of increase from 14 percent in 74-75 (over 73-74) to an estimated 8.9 percent in the current 77-78 year. This indicates that hospitals operating in states with budget review and rate control have been able to effectively reduce their costs—but only within a reasonable time frame. In this way, a hospital has an opportunity to bring costs under control in a planned way without adverse effect on the care it delivers. Knowing a mandated deadline is present, hospitals given a reasonable time (three years seems appropriate) will measure up to their responsibilities in an expert manner.

2. Many of the elements proposed in S. 1470 and H.R. 7079 by Senator Talmadge and Rep. Rogers are more appropriate to pursue as a cost containment program. The basic concept of prospective reimbursement embodied in their act is a principle that must be implemented. This will create a measure of efficiency and recognizes the need for growth and development. Hospitals which cannot control their costs under this concept will be forced to close beds, etc. achieving the cost control desired.

3. Any program adopted should be expanded to include federal hospitals, physicians and other health institutions. Physicians especially impact greatly on health care costs and an unfair burden is placed on hospitals when they are not considered.

4. Consider the noncontrollable (by hospitals) effects of increases in malpractice premiums, energy, food and other hospital costs, as now considered in the revised Talmadge proposal. A forward thinking revision.

5. Allow the provisions of Public Law 93-461 to take hold regarding capital expenditures. The HSA mechanism should be allowed to achieve the intended results. In our area alone, we feel success has and will continue to be achieved by the HSA. This has demonstrated that community needs are best known and evaluated at the local level.

6. The several State Rate Review-Cost Containment Programs appear to have achieved certain success and they are properly modified with time to fit the needs of the state and local areas involved. No federal program can be that flexible. Most health care providers and consultants recommend a state developed program with federal guidelines. In this way, the states can be held responsible for excesses and will be sure to reduce and eliminate these excesses. Establish state timetables to formulate effective plans.

If it appears that the development of a more reasonable and comprehensive plan is not in the offing and a majority of Congress feel the "urgency" to adopt quick legislation in fiscal 1978, many of the above suggestions and those below can be used to modify H.R. 6575. These include an incentive-based prospective reimbursement program with a built in growth/development factor, expansion of

the scope to include physicians, expanding the exemptions (insurance, energy costs), improve and better define exception criteria to recognize intensity and new services separately from financial hardship, strengthen HSA's to adequately cope with a new program, provide for mix changes between classes of payors and type of services which has a profound effect on revenue and re-define the base year concept to the year just preceding the control year.

I sincerely hope this provides some constructive alternatives for consideration. Please feel free to write or call me if you need more clarification on any of the above.

Sincerely yours,

RICHARD F. MANGES,
Director of Financial Services.

STATEMENT OF THE AMERICAN PROTESTANT HOSPITAL ASSOCIATION

INTRODUCTION

Mr. Chairman, we appreciate the opportunity to submit our opinions to your Subcommittee on the subject of hospital cost controls. The American Protestant Hospital Association represents some 300 hospitals, homes for the aging, and other health care agencies throughout the country, as well as some 2,000 personal members who are engaged in the delivery of health care services. The Association membership is dedicated to providing quality health care to patients within a Christian reference and to ensuring the strength and viability of our voluntary, pluralistic health care delivery system.

S. 1391

APHA is opposed to S. 1391, the Administration's hospital cost control proposal, as originally introduced and as reported by the Human Resources Committee. The plan is based upon an unsound concept: limiting hospital revenues to an arbitrary percentage limit without consideration for the variety in hospital size and services. This cap would apply equally to the efficiently-run facility as to the inefficient. In addition, it ignores the reasons for hospital cost increases. There is no incentive to hold down costs so we may find the "cap" becoming a floor.

We feel that the Administration's proposal, S. 1391, as reported by Human Resources, will dramatically reduce the quality and scope of services rendered. The nine percent limit will be a disincentive to the continuation of hospital outpatient services, because money from inpatient services will no longer be available to carry the loss. The plan will further discourage hospitals from having more intensive types of care or long-term care services but rather will encourage a hospital to refer such patients to other institutions.

A particular item in S. 1391 of concern to APHA members is the process for getting an exception to the revenue limits. Will philanthropic reserves be considered in determining the ratio of assets to liabilities? Typically, these funds are bequeathed to our hospitals with usage restricted by stipulations of the will. What are the implications here for charitable contributions? It would seem that the unrestricted funds at least would have to be liquidated, thereby depleting the reserves of a hospital that never could be replaced. Philanthropy for hospitals would dry up, causing a significant impact on other sources of funding. Obviously, a hospital forced to operate on the verge of bankruptcy in order to gain an exception to the revenue limits would be considered a poor lending risk by any financial institution.

Mr. Chairman, the hospital plays such an integral role in our health care delivery system that the American Protestant Hospital Association strongly urges you, rather than risk chaos and ruin with the Administration's hastily devised and ill-considered proposal, to work with your own proposal, S. 1470, which we feel is based upon sound principle—hospital incentives for controlling costs, and which, with modifications, we can support.

S. 1470

Mr. Chairman, as we so testified before your Subcommittee in June, APHA appreciates your concern for rising health care costs, and we are grateful for your commitment to the development of hospital reimbursement reforms that are based on a recognition of the factors that are responsible for such increases. APHA also recognizes that total health care costs have escalated and believes we have a responsibility to constrain these costs wherever possible while main-

taining high quality services. We believe the Talmadge proposal is a good beginning towards this end, and with modifications we can accept this plan.

We are pleased to note that one of your proposed changes to the bill extends its coverage to all payors. We further suggest that S.1470 include all hospitals (Veterans Administration, public general, private non-profit, proprietary, etc.). We believe to successfully control the rapid escalation in hospital costs that all hospitals must be subjected to the same rules and that all payors be included in the plan.

Section 2—Criteria for Determining Reasonable Cost of Hospital Services

APHA supports the establishment of a uniform reporting system to facilitate cost comparisons between hospitals and the establishment of an accurate hospital classification system. We do not, however, support a uniform accounting system, if this is the legislative intent, as it would be an infringement upon management prerogative and unnecessary for making cost comparisons if a uniform reporting system is developed.

The proposed classification system concerns us due to the great diversity among hospitals. We recommend that the classification system be devised with full consultation from the field of health care and government agencies. Technical aspects could be worked out by a panel of experts who have been involved in Medicare-Medicaid reimbursement matters over the years. Representatives should include persons from associations of providers, Social Security Administration, health care institutions, Congressional staff, Blue Cross Association, and etc. We believe that a prerequisite for an equitable and accurate classification system is good hospital data base. Therefore, we recommend the gradual phasing in of any such system as an accurate data base evolves.

We recommend that determination of the total financial requirements of hospitals be made on the state level under federal guidelines. It is felt that state review and determination of hospital financial requirements can better account for the uniqueness of each hospital than would be the case if determined solely on the federal level. Once such rates are established, these should be required of *all* payors. In addition, we feel payments to hospitals should be made on a prospective basis in order to facilitate hospital budgeting for the fiscal year.

We are pleased that the legislation recognizes the problem of high malpractice premiums hospitals must pay and exempts from the definition of "routine operating costs." However, we feel that general liability insurance should be excluded as well since it is normally sold with malpractice coverage in one package. Hospital self-insurance seems to cost substantially less than commercial insurance rates, a fact recognized by HEW in its allowing Medicare reimbursement for such costs. Yet, the large monetary reserve necessary to create a self-insurance trust fund is a barrier to many hospitals. Therefore, we recommend federal assistance in establishing self-insurance programs.

To encourage the continuation of philanthropic giving to hospitals, APHA recommends that the legislation specifically prohibit requiring the deduction of unrestricted gifts and endowment income from the reimbursements. Philanthropy has provided needed funds for approved hospital capital expenditures that would have to be replaced by all payors if this source was unavailable. In addition, philanthropy has served the non-profit field as venture capital has served industry. It has permitted hospitals to try new techniques of care as well as of organization and has encouraged needed research into the cure and prevention of disease. In the case of church-related hospitals, philanthropy has enabled us to meet our Christian responsibility to care for all sick people regardless of ability to pay. Therefore, we feel specific language should be included in the bill to protect this important source of funding.

Section 3—Payments to Promote Closing and Conversion of Underutilized Facilities

We support the demonstration project proposed in Section 3 by which federal financial support would be provided institutions which apply for such support on the basis that their operations would be made more efficient or cost-effective by the closing or conversion of underutilized beds and that they would also become eligible for positive incentives under the provisions of Section 2. However, we recommend that the overbedding or underutilization determination be made on the local level through the health systems agencies, maintaining the appeals procedures. We further recommend as an alternative to closing excess

bed capacity the employment of the "swing bed" concept whereby an acute care hospital bed can be used for long term care.

Section 4—Federal Participation in Hospital Capital Expenditures

APHA supports the application of certificate of need requirements for capital expenditures in excess of \$100,000 in all settings, including physicians' offices, to deal with the growing problem of expensive diagnostic equipment. However, we recommend that actual physicians' office buildings be excluded from CON requirements.

Section 12—Hospital-Associated Physicians

APHA believes that state rate review under federal guidelines is the best method to determine the reasonableness of hospital contracts with physicians for purposes of reimbursement. To enact legislation prohibiting a specific type of contract, we feel, removes decision making from its proper authority—management and the governing boards—and places it in Washington.

Section 30—Establishment of Health Care Financing Administration

APHA supports this section. However, we recommend as a mechanism for the most effective coordination of the setting of national health policies and administration of federal health programs the creation of a cabinet-level Department of Health.

Section 40—Procedures for Determining Reasonable Cost and Reasonable Charges

APHA vigorously opposes this section. The proposal is a gross infringement on the management prerogative of individual institutions.

Section 46—Rate of Return on Net Equity for For-Profit Hospitals

APHA supports the principle implemented in this section—that an adequate return on investment is a reasonable expectation in business. However, we recommend that this section be more broadly written to recognize the total financial requirements of *all* hospitals. Return on net equity would be one requirement of proprietary hospitals while an adequate operating margin would be necessary for non-profit institutions as would be the cost of charity care, educational programs, and generally more acute level of care provided.

CONCLUSION

The American Protestant Hospital Association fears the confusion and uncertainty that the Administration's proposal (S. 1391) would create could eliminate much of the progress hospitals have made in patient care by forcing a reduction in existing services. Rather than risk this tragedy by employing the drastic, hatchet techniques of S. 1391, we urge you to consider the permanent reforms that would result from a modified version of S. 1470. While we have concerns over your addition to S. 1470 of revenue limits for ancillary services, we stand ready to assist you in devising a sound basis for these limits as well as to aid you in improving other aspects of your bill.

Thank you for this opportunity to present our views.

STATEMENT OF AMERICAN NURSES' ASSOCIATION

The American Nurses' Association submits this statement for the record in response to the Cost Containment Act of 1977, S. 1391 and S. 1470 and related bills. ANA is the national professional association of registered nurses and as such, has a keen interest in the impact of cost controls on the quality and quantity of health care services.

The ANA shares the concern of the government, citizens and other health providers over the problems created for all of us by rising costs in hospitals, as well as the increasing costs in other parts of the delivery system such as nursing homes. We support all appropriate efforts to restrain these rising costs and offer nursing's assistance in solving the problems. S. 1391 and S. 1470 are dramatic efforts on the part of the Congress and the administration to gain reasonable dis-

cussion for cost containment and to seek cooperation and commitment for action to solve the cost dilemma. We support the purposes of this legislation as stated in the bill preambles.

In our June 13, 1977, statement to this subcommittee on S. 1470, we stated "S. 1470 is a laudable effort to initiate steps for cost containment and to seek cooperation and commitment for action to solve the soaring cost dilemma." We again draw your attention to page 3 of that statement where we pointed out that 40-60 percent of operating budgets of hospitals are shown as nursing budgets and that nursing is an income producing department. Yet nursing service costs are rarely identified as such to either the consumer or the public. Therefore, in the latest version of S. 1470 we are concerned to still see routine nursing included in basic room and board charges. The nursing care costs for patients varies considerably depending on the intensity of care, teaching required and so on. We do urge this committee to take a careful look at the implications of continuing this hospital practice prior to your markup of these bills.

Everyone in this country is affected by increasing costs of hospital and health services. For those who need to use the services there is an increasing expectation for accuracy of diagnosis, timely and effective treatment and humane care—indeed the miracles of relief from pain, fear and anxiety.

For those who work in hospitals and health care services there is the expectation that the tools, equipment and environment for the delivery of care shall be safe, effective, available, time efficient, clean, and supportive to the care delivered. Further, these workers both professional and non-professional expect appropriate compensation, job security and recognition for their services, their skills and the contributions they make to the care of the ill and their families.

It is not surprising that the costs of care in hospitals have increased. These costs can and must be viewed as an investment which has been of benefit to thousands and is socially desirable for millions who benefit from the treatment and the cure of people who require hospitalization in order to return to their families and the work force of this nation.

For too many years the tools and equipment were inadequate for the jobs to be done. For too many years the workers, both professional and nonprofessional were inadequate in number, lacking in appropriate skills for the growing complexity of the illness and treatment modalities and grossly underpaid. For too many years hospital trustees adopted policies for expansion of facilities and services on the "keeping up with the Joneses theory" with little accountability for the inflationary aspects of these policy directions. Many institutions were poorly managed and they neither sought nor received public support. When public support did become a major factor, beginning in the early 50's, it was not predicated on any real reform of the inflationary policies already built into the system, but, on the contrary, reinforced and accelerated them.

Responsible attention to correcting these rapidly rising expenditures is required, and the task involves more than simplistic solutions. In spite of a variety of efforts to examine the causes of increasing costs and in spite of some general agreement that there are a variety of factors included in the list of causes, there is no general agreement about the relative importance of the factors. Is it not useful to believe that this disagreement is valid and that institutions do indeed vary and that specific factors may predominate as causes in large institutions, but not affect the small? Or is size the real determinant? We have in this country attempted to classify hospitals in a variety of ways, but perhaps these classifications are not the most useful. Perhaps large teaching institutions are not alike. Perhaps all hospitals in the 100 to 200 bed categories, often used for a variety of averages and comparisons, are indeed quite different. The proposal of this subcommittee to allow variations in formulas for cost control according to a hospital classification system is one we agree with. Intensity of care is a major factor in determining the true cost of a patient's care, and therefore, hospitals with severely ill patients must be handled differently from a small local hospital that does no major surgery, etc.

It is our belief that the provisions of the Administration's bill to control revenues to hospitals by all payors without appropriate reform of the structure of the system of health care delivery and reimbursement is unworkable, rigid and not an appropriate effort without major revision. As a "transition" proposal it contains no expiration date. Other flaws are numerous. We will address these as follows, being aware that the additions to S. 1470 do address some of our concerns:

1. To decrease the rate of inflation for health expenditures by attacking only one segment—hospitals—will not be a long-term solution.

Failure of the legislation to address the actual expenditures for fuel, food, insurance of all types, and supplies which vary by region and locality, size and purchasing power, etc., will most likely be inequitable for many institutions. Not including some restraint on physician charges and other institutional providers is inequitable.

2. To decrease the rate of inflation for health expenditures without altering the system of reimbursement will deter effective management innovation and control.

The cost reimbursement system is known to be inefficient and provides little incentive for effective management control. The third party system for reimbursement encourages institutional care and does not promote public awareness of understanding of the real cost of health care. The present reimbursement system of medicare and medicaid which does not include reimbursement for services of primary care nurses who can and are able to keep people out of institutions must be altered.

3. To decrease the rate of expenditures for health through a cap on the revenues of hospitals as in S. 1391 will affect the care and services to those who are hospitalized.

Even if many hospitals which have been operating as cost effectively as possible could tolerate a 9 percent cap on revenues for one year without reducing essential staff or needed services, one year would probably be all that could be tolerated; then staff, services, and indeed quality of care would be reduced.

Although the administration's legislation provides for an exemption for non-supervisory wages—if requested by the institution and limited to an 18-month period for review of the exemption by the Secretary—the provision is not clear and is discriminatory by not including the very supervisory persons who are essential to implementing any cost effective reforms in the structure and delivery of care system. We prefer the wording in S. 1391 which makes the wage pass through mandatory. We think the groups included in the pass through should at least be, all staff not in policy-making positions.

The bill places responsibility for certain monitoring and reporting on the health systems agencies (HSA's). A vital part of the ability of HSA's to fulfill that role depends on mechanisms such as PSRO, and yet it is well known that this review system is inadequately developed. Utilization review as part of that mechanism is perhaps implemented in the majority of institutions. It addresses only the lengths of stay and necessity of admission and has little or no value in determining the quality of appropriateness of the services rendered. However, even if the whole of PSRO were presently operational and standards developed for assessing the adequacy of services provided, that monitoring system has limited value because it does not include the review of all health components but focuses only on medical/physician services. The PSRO system must be altered to include appropriate attention to all professional services including nursing.

4. To decrease the rate of expenditures for health by a revenue cap for hospitals and require certain monitoring functions to be carried by health planning agencies such as HSA's will fail. The S. 1470 approach of allowing for adjustments in revenue based on identified specific areas of differences seems much more workable and fair.

The implementation of Public Law 93-641 is two years behind schedule. HSA's are not functional in many areas. Those which are beginning to take hold of what it is they are about are still waiting for guidelines from HEW in order to implement their role. Priorities are not operational. Funding is and has been totally inadequate. How then can this mechanism be effective in monitoring a whole new set of problems related to implementation of cost control legislation?

The ANA is most supportive of the health planning legislation and has urged without success, strong nurse representation on the National Council on Health Planning and Development. Unilateral planning and policy decisions by medicine and hospital managers in this country must not continue, and this committee has the authority to mandate the needed changes.

We suggest that such narrow participation in policy-making (by so few groups) is the underlying cause of the problems in health delivery and the high rate of inflation in the industry, and if allowed to continue, the problems also will continue.

We suggest that in the most effective and cost efficient hospitals in this country you will find that all health professional departments work as a team in true

colleague relationships with the hospital administration and with the medical staff. Unless this same partnership exists at the federal planning level as well as at the local level it will be less than effective.

5. To attempt to decrease the rate of inflation for health expenditures by attacking the acute care inpatient services without providing opportunities to develop and expand alternative approaches to inpatient care can, at best, be of only temporary benefit. The health system has to be looked at as a whole if cost controls are to be effective without decreasing the quality of care.

The goal of cost containment in hospitals must be pursued in a manner that is compatible with the needs of people. Determinations about what is "medically necessary" care or more importantly, what is "health maintenance necessary care," must not be the exclusive prerogative of one professional group. Opportunities for developing different models of ambulatory care, home health care, etc., must be in place if more costly services are to be curtailed.

Insurance benefits must be turned around to encourage these less costly modes of services, and include nurses as providers of these services.

6. To decrease the rate of inflation in expenditures for health through a transitional program of revenue caps when present indexes are indicating that a slow down in the rate of inflation is already occurring seems strange.

The administration's proposed legislation calls for a report by the Secretary of HEW by March 1978 directed toward more permanent reforms. There is general agreement that reforms must take place. There is general agreement that more data and knowledge about the cause of inflation and the effects of alternative approaches is required.

Is it not also reasonable that if there is an apparent slowing of the rate of inflation in the health sector this year that the energies of the government and the health sector should be directed to the more desirable alternatives for a long-range plan? Especially now that we have entered a new federal fiscal year without enactment of these bills the timing question is important.

7. To decrease the rate of inflation in expenditures for health care by a revenue cap which carries a section (113) for an admission load formula, which is inadequately conceived will reduce the quality and quantity of services required for safe care of inpatients.

The formula presumes that hospitals are so inefficient that they can absorb a 5 percent increase of patients at half the cost of the base number of patients. We suggest that is not possible for any hospital to predict or to manage.

The bill assumes that hospitals have the power to admit or not admit patients. It places no burden of responsibility or accountability on the physician. It provides no sanctions on the physicians to comply with PSRO and utilization review to constrain admissions and lengths of stay and to establish appropriate standards of services required.

CONCLUSION

The American Nurses' Association is dedicated to the provision of high standards of nursing services for patients.

We support the objectives of the Administration and the Congress in their efforts to restrain health care costs.

We believe that a long term program for the system as a whole would be more helpful than a short term rigid program.

The American Nurses' Association supports uniform reporting mechanisms and public disclosure of hospital costs including those for labor management legal fees, salaries of top administration and fees and membership costs that are included in the medicare/medicaid reimbursement formulas.

The American Nurses' Association supports restraints on capital expenditures, but does believe that allocation of resources based on geographic differences and type of services needed must be possible.

The American Nurses' Association wishes to participate in designing and implementing alternative plans for cost containment. What is required is true collaboration by the variety of health professionals working with the public. Nursing offers its cooperation to the Congress and the Administration in developing a coherent national policy for health.

STATE OF ALABAMA,
GOVERNOR'S OFFICE,
Montgomery, Ala., October 7, 1977.

Hon. HERMAN E. TALMADGE,
*U.S. Senator,
Russell Building,
Washington, D.C.*

DEAR SENATOR: It is my understanding that your subcommittee on Health is scheduled to hold hearings on legislation dealing with the problems of kidney failure, dialysis and transplantation. I am very interested in this problem and would like to make my views known.

I, as well as anyone, realize that medical costs have gone up and continue to go up everyday. To say that individuals should be placed on home dialysis as a means of reducing the cost of dialysis treatment would seem to infringe on the right of freedom of choice of the patient and his physician.

I agree that all suitable patients should be encouraged for self-care, or home dialysis, but the selection of the patients involved must remain the right of the physician and patient. For Congress to try and mandate specific forms of therapy for individual patients regardless of the patients wishes would, in my opinion, be completely unjustified.

The matter of End Stage Renal Diseases is a grave problem confronting some 40,000-42,000 American citizens. It is a day to day matter of life and death. One of the great advantages of this program has been that each patient has been able to receive the type of treatment and care best suited to his own individual medical and social situation without pressure from the federal government. I think it would be a mistake for the federal government to advocate any form of medical treatment or incentive other than optimum medical treatment.

With kind personal regards, I am

Sincerely yours,

GEORGE C. WALLACE, *Governor.*

AMERICAN SOCIETY OF TRANSPLANT SURGEONS,
Columbus, Ohio, September 20, 1977.

Hon. DAN ROSTENKOWSKI,
*U.S. House of Representatives,
Washington, D.C.*

DEAR MR. ROSTENKOWSKI: I have read the report of the Committee on Ways and Means, U.S. House of Representatives on H128423, and wish to commend your committee for their fine effort. The report shows substantial insight into the problems facing nephrologists and transplant surgeons but, most importantly, facing those patients with the disability of chronic end-stage renal disease.

The recommendations of your committee will make substantial improvements in many of the shortcomings of the previous legislation. I would, however, like to comment on certain sections of the Bill, and I will do this on a section-by-section basis, as outlined in the report.

(1) Purpose and background of the bill

The recommended elimination of disincentives for transplantation will markedly improve the coverage for patients undergoing transplantation and certainly will ease the financial burden of those patients. The four specific recommendations demonstrate a thorough analysis of the practical day-to-day problems of taking care of these patients.

The Bill addresses the problem of peer review for dialysis and transplantation. One of the problems with local peer review for dialysis and transplantation patients that is becoming obvious is the lack of objectivity when small geographic areas control the future of these patients as well as the numbers of dialysis and transplant centers. There are certainly many advantages to having local regions determine the (a) performance of facilities, (b) need for new facilities, and (c) adequacy of patient care, but it is our view that an impartial non-regional input is mandatory to prevent a continued spiralling of costs. Unfortunately,

current Medicare guidelines (a) encourage the proliferation of small and local transplant centers, and (b) encourage the maintenance of patients on dialysis, rather than transfer them to major transplant centers.

We would hope, therefore, that the Committee would address itself to further mechanisms for preventing the further proliferation of dialysis and transplant centers, a proliferation which is accompanied by an increase in cost, as well as a decrease in quality of patient care. It has been shown in several studies that the smaller transplant unit has a higher patient mortality and morbidity, as well as a decrease in the quality of care. Yet, almost every nephrology group desires to have their own individual transplant center and, as a result of this, a proliferation of transplant centers is being encouraged by many of the regional networks.

(2) *General statement*

(A) Two years of Medicare coverage following transplantation would be enough and three years is rarely necessary. In two years, the overall majority of patients either have a well functioning, stable graft or have required transplant nephrectomy and are being considered for re-transplantation. An analysis of the kidney graft survival curve indicates that at two years posttransplantation, the survival begins to plateau and two years of coverage would seem to be more than adequate.

(B) The immediate resumption of coverage without a waiting period once a transplant fails is an excellent addition to the Medicare coverage and certainly would greatly ease many of the patients' problems.

(C) Reimbursement Methods. One of the problems in certain parts of the country has been the sequestration of patients by the nephrologists, rather than refer them to transplantation. This has been true mainly in areas where there has been an over-abundance of dialysis capability or poor local results with transplantation. For these reasons we suggest that a careful control on the proliferation of new dialysis facilities be instituted so that this sequestration is not encouraged. As the report indicates, the best therapy for most patients with chronic end-stage renal disease from multiple points of view is transplantation. In order to discourage sequestration of patients, all patients who are on dialysis should have a statement signed by a transplant surgeon within six months saying that this patient has been reviewed by him and in his opinion the patient is either an excellent or poor or fair transplant risk, and has been well informed regarding the relative merits of transplantation and dialysis. This data could be reviewed at appropriate times to determine if sequestration of an excellent transplantation candidate is occurring.

(D) Studies, Reports and Administration. It is clear that the cost of the overall program would be significantly decreased if a greater number of kidneys were available. Therefore, we encourage any program that would maximize the number of available organs. The risk of malpractice action is one of the major inhibitory factors in the procurement of increased numbers of cadaveric donor kidneys. Recognition of adequate brain death criteria, or possibly even the encouragement of a "Good Samaritan" malpractice protection for physicians and hospital administrations participating in organ procurement if the proper guidelines are followed, would certainly be helpful in increasing the supply of kidneys.

Oversight findings

The current guidelines state that only 10 to 15 kidney transplants need be performed before a center is eligible for reimbursement. This is entirely inappropriate. There are currently over 200 transplant centers in the country, which is a number more than adequate to cover the projected needs of the nation for years to come. As the number of transplant centers proliferates, the use of each individual center, therefore, decreases. This means that there is a marked duplication of trained personnel, equipment and space, which greatly adds to the costs. Not only does it add to the cost, but it leads to decreased patient survival and increased morbidity. For these reasons, therefore, it is suggested that the minimal number of transplants required before a center be eligible for funding be markedly increased to between 30-35. It is impossible to keep a trained corps of nurses, perfusion technicians, outpatient personnel and physicians unless at least this number of transplants is being performed. It makes little medical or economic sense to have two underutilized facilities within a community with its duplication of costs. Therefore, before other dialysis or transplant centers are approved for funding, a clear need should be demonstrated within a community, and this need must be evaluated, not only by the local physicians, but also by an impartial representation at the national level. In addition, the original guidelines of 10-15 transplants per year were established to discourage transplant center prolifera-

tion. However, the exact opposite has occurred in many centers. Small nephrology groups have sequestered their patients for several months or even years and then released them for transplantation within a short period, thus qualifying for reimbursement under current guidelines but by no means meeting the spirit and intent of the original legislation.

The current legislation allows an exception in the minimum number of required transplants for children's hospitals. We feel this is not in the interest of providing optimal care to pediatric transplant candidates. Almost all children receiving transplants are within an age group that permits safe and efficient transplant care in an adult transplant center. It is much more appropriate to have the pediatrician consult at the major transplant center than to develop a pediatric transplant facility with its expected low utilization rate in a children's hospital. Therefore, children's hospitals should not be exempt from the minimal number of required transplants for reimbursement eligibility.

The report addresses the problem of decreasing utilization of home dialysis by improved reimbursement and by requiring a fixed ratio of home to center dialysis but most patients, if given equal reimbursement coverage for home as compared to regional dialysis centers, would prefer the center dialysis because of its lesser disruption of the family and greater convenience. Therefore, the establishment of a fixed ratio of home to center dialysis seems appropriate and necessary, providing some consideration is given to local geographic and socioeconomic conditions.

In summary, therefore, we feel that this Bill represents a substantial improvement over the current Medicare regulations for the management of patients with end-stage disease. Areas that are deserving of fuller consideration within the Bill are: (a) a more careful and rigid set of guidelines for the establishment of new dialysis and transplant centers, (b) incentives for the procurement of additional cadaveric organs, and (c) stronger safeguards that possible transplant candidates are referred to transplantation at the appropriate time.

We feel that the Committee should be congratulated for its efforts and insight and, again, we wish to offer our services as an informational resource for any future deliberations for the Committee. It is our goal to provide the maximum level of care at the minimal cost to patients with end-stage renal disease, and I am sure that you would find the resources of the American Society of Transplant Surgeons useful in your future deliberations.

Sincerely,

JAMES CERILLI, M.D., *Secretary.*

AMERICAN SOCIETY OF TRANSPLANT SURGEONS,
Columbus, Ohio, September 30, 1977.

Hon. HERMAN E. TALMADGE,
U.S. Senate,
Senate Finance Committee,
Washington, D.C.

DEAR SENATOR TALMADGE: I am writing you in my capacity as Secretary of the American Society of Transplant Surgeons. This organization consists of essentially all of the surgeons in this country who have been adequately trained as transplantation surgeons and who are actively engaged in transplantation research and patient care. The goals of the Society are to improve research, education and patient care in the field of transplantation.

H.R. 8423 has cleared the House and it is our understanding that it is under consideration by the Senate Finance Committee. The American Society of Transplant Surgeons wishes to offer its expertise and knowledge to the Senate Finance Committee with the goal of improving the care of patients with end-stage renal disease and minimizing its cost. It is my understanding that hearings are to begin on the bill on October 11, 1977. Enclosed you will find a copy of a letter recently sent to Mr. Rostenkowski, and it is our hope that these comments will be actively reviewed by the Senate Finance Committee. Unfortunately, the Society was unaware of H.R. 8423 at the time of the House hearings and, therefore, the views of those physicians performing essentially all of the transplantation in this country were never formally presented. I, as well as other members of the Society, would be pleased to participate in the hearings if you feel it would be helpful.

Sincerely,

JAMES CERILLI, M.D.,
Professor of Surgery, Ohio State University.

AMERICAN SOCIETY OF TRANSPLANT SURGEONS,
Columbus, Ohio, September 30, 1977.

MR. JAY CONSTANTINE,
Senate Finance Committee,
Washington, D.C.

DEAR MR. CONSTANTINE: I am writing to you in my capacity as Secretary of the American Society of Transplant Surgeons. This organization consists of over 240 transplant surgeons in the United States and has the primary goal of promoting education and research in the field of transplantation. The members of the Society also have an interest in the improvement of patient care for patients with end-stage renal disease. It is my understanding that a bill is now before the Senate Finance Committee, formally known as H.R. 8423, that deals with alterations in the Medicare end-stage renal disease coverage. I have written a letter to Senator Talmadge incorporating a copy of a letter that we had sent to Mr. Rostenkowski. This letter discusses some of the aspects of the House Bill that we felt could be improved. Unfortunately, the Society was unaware of the bill in time to present its views at the House hearings. We feel that many of the concepts presented in the letter to Mr. Rostenkowski would represent an improvement in the bill, particularly in improving patient care and minimizing costs. It is our hope that the views of the American Society of Transplant Surgeons can be expressed at the hearings that are to begin October 11. I, or other members of the Society, would be pleased to discuss the bill with members of the Committee and their staffs, at any time.

Sincerely,

JAMES CERILLI, M.D.,
Professor of Surgery,
Ohio State University.

KAISER FOUNDATION HEALTH PLAN, INC.

REASONING FOR THE EXEMPTION OF HMO HOSPITALS FROM LIMITATION ON CAPITAL EXPENDITURES (S. 1391)

HMOs are not asking to be exempted from the general hospital planning process under P.L. 93-641—their capital expenditures should be reviewed and justified as to need.

However, HMO hospitals must be exempted from the 2.5 billion dollar hospital capital limitation—to place them under that limitation would effectively stop all growth of hospital based HMOs which are the most efficient form of health care delivery system in existence in the U.S.A. today.

1. Hospital based HMOs have proven records of cost containment.

(a) HMO hospitalization rates are decreasing; the nation's rates are increasing.

(b) HMO facilities are used appropriately:

Kaiser—1.5 beds per 1,000 population;

U.S.—4-5 beds per 1,000 population; and

Kaiser has 2 CAT Scanners for 2.5 million population.

The San Francisco Bay Area has more than 20 CAT Scanners.

2. HMOs, as tools for cost containment, should be allowed and encouraged to grow, to cover more of the population and to stimulate competitive efficiencies.

3. Growth is dependent on ready availability of facilities controlled by the HMO.

4. Ready availability of facilities is dependent upon capital availability.

5. If allocation of capital is subject to limitation by arbitrary division within a region, HMOs will be discriminated against: i.e., they will not be allocated the use of funds necessary to meet growth time tables.

6. Capital expenditures for HMOs have the effect of reducing total operating costs for health care in amounts that exceed the capital costs (i.e., favorable return on investment for the community).

7. The exemption of HMO hospitals from the limitation on capital expenditures is consistent with Congressional and Executive Branch intent to provide an incentive for the private sector to control costs in health care.

STATEMENT OF HOWARD F. COOK, PRESIDENT, CHICAGO HOSPITAL COUNCIL

I am Howard F. Cook, president of the Chicago Hospital Council. The Chicago Hospital Council was established in 1935. Our membership now includes 100 metropolitan Chicago hospitals. The Council's primary purpose is to help our member hospitals meet the public's needs for hospital facilities and services.

The Chicago Hospital Council strongly opposes "The Hospital Cost Control Act of 1977" (S1391) for the following reasons:

1. The legislation limits hospital revenues while doing nothing to control significantly rising costs hospitals incur in providing patient care.

2. The bill ignores the numerous controls which have been effected by federal and state governments in recent years.

3. The proposed legislation improperly assumes that hospitals are generally wasteful and inefficient.

4. We must seriously question the Federal Government's ability to properly administer the program.

The legislation limits hospital revenues while doing nothing to control significantly rising costs hospitals incur in providing patient care.—The reasons for hospital cost increases are many and complex. However, S. 1391 does nothing to identify and correct those reasons. As a result, hospital expenses would soon exceed revenues, meaning financial disaster for hospitals. The only other alternatives would be significantly reduced availability and quality of hospital services.

Hospitals, like other industries, purchase goods and services in the general marketplace. However, the general inflation rate does not properly explain hospitals' increased costs for goods and services purchased in the general marketplace. That is because many of the goods and services hospitals purchase have increased at rates substantially higher than the general inflation rate. For example, malpractice insurance premiums for Chicago-area hospitals increased 1,247 percent between 1971 and 1976. As a result, malpractice insurance which had cost \$0.74 per patient day in 1971, cost \$8.79 per patient day in 1976.

Yet, only about 53 percent of the increased cost of hospital care is attributable to increases in the costs of goods and services hospitals purchase. The remainder is due to the increased intensity of service. That is, the hospitalized patient today receives more services per day and per stay than was true several years ago. This is partly because many of the services provided today weren't even available 5 or 10 years ago. It is also due to other factors including an older population, and a change in the type of patient hospitalized (e.g. patients are no longer hospitalized for croup). These intensity changes are almost exclusively beyond the hospital's control. Many of the new services (radiation therapy, open heart surgery, kidney transplantation, etc.) mean people are alive and productive today who, not many years ago, would have died or would have lived as invalids.

One example of the effect of changing intensity is the increase in laboratory tests. In metropolitan Chicago, the average hospital in-patient received 94 percent more laboratory tests in 1976 than he had in 1969.

Government and quasi-government regulation itself has increased hospital costs. One large Chicago hospital reports that meeting newly changed life safety codes will cost it \$12 million. The facility must meet those standards to continue participation in Medicare and Medicaid. Further, concurrent stay review now required by Medicare and Medicaid utilization review regulations and the Professional Standards Review Organization Program costs a conservatively estimated \$10 per patient stay. While length of stay has been declining, that trend was evident before these programs were implemented; and there has been no conclusive proof that they are effective. These are but two of many examples of government caused cost increases.

Clearly, S. 1391 will do nothing to deal with these and the many other complex reasons for hospital cost increases. While hospitals, like any industry (including government) can always squeeze out some additional savings, the net result would have to be the reduced availability and quality of care. While the public, hospitals, and government must all be concerned about the high cost of health care, there is no indication that the public is willing to accept the reduced availability or quality of care that would result from passage of S. 1391.

With S. 1391 controlling revenues, but not costs, the fiscal impact upon Chicago-area hospitals would be disastrous. Between 1977 and 1980 we project hospital

costs would exceed allowable revenues by roughly \$560 million. The excess of costs over revenues would hit \$293 million in 1980 alone. Thus, by 1980, Chicago-area hospitals will be paid about 90 percent of their total costs. That would be catastrophic with respect to cash flow, and it would have to mean a reduction in availability and quality of service. It would also mean a halt to developing new and improved services.

The bill ignores the numerous controls which have been effected by federal and State governments in recent years.—The bill ignores that in recent years government, at both the Federal and State levels, has instituted numerous cost-containment measures. Those include Medicare and Medicaid utilization review regulations, the Professional Standards Review Organization Program, Health Systems Agencies, Medicare and Medicaid reimbursement ceilings, and, in Illinois, as in many other States, certificate of need legislation. These programs are all relatively new, and they have not been in place long enough to properly assess their impact.

Further, the Federal Government does not appear to have established effective mechanisms for evaluating the impact of these recently established controls. Superimposing additional controls will result in confusion, duplication of regulatory activities, and no evaluation of which regulatory mechanisms, if any, are effective in controlling cost increases.

Those countries which have embarked upon the equivalency of complete regulation through government operation of health care facilities have experienced exactly the same result as we have in the United States—uncontrollable hospital costs. Thus, we must carefully test and evaluate the various control mechanisms which are being proposed to insure that they are cost-effective and not dangerous to our Nation's health.

S. 1391 asks the Nation's hospitals to achieve a goal that the Federal Government apparently has not been able to achieve itself. We looked at the cost increases for the three short-term Veterans' Administration hospitals in metropolitan Chicago for the years 1974-75. The data were from the American Hospital Association's "Guide to the Health Care Field" published in 1975 and 1976. The cost increases for the three hospitals averaged 17.1 percent per patient day, and total expenses increased an average of 13.1 percent. These average increases are significantly greater than the roughly 9 percent cap contained in S. 1391.

Our presentation of these figures is not meant to cast the Chicago-area Veterans Hospitals in a bad light. They are excellent hospitals. However, the figures for those hospitals clearly illustrate how unrealistic S. 1391 is.

The proposed legislation improperly assumes that hospitals are generally wasteful and inefficient.—We often hear that hospitals lack incentives to contain costs. Yet, when one looks objectively one sees that hospitals have voluntarily attempted to contain costs and have an excellent list of achievements in this regard. Some Chicago-area examples indicate this very clearly.

As long ago as 1961 Chicago-area hospitals were among the first in the country to support utilization review. The Chicago Hospital Council, together with the Chicago Medical Society, Chicago Blue Cross, the Chicago Federation of Labor, and the Chicago Association of Commerce and Industry, developed and issued a statement urging hospitals and doctors to establish committees to evaluate utilization. The statement also urged individual members of the public to "use but not abuse" hospital insurance, and employers to provide hospital insurance coverage with utilization controls. The Chicago Hospital Council continued by assisting our member hospitals in such efforts. For these and other reasons, length of stay declined in the 1960's and 1970's, well before government programs took hold. This decline in length of stay is even more commendable when we remember that the number and proportion of aged persons increased during the same period of time.

Chicago-area hospitals' support of hospital planning goes back to the 1950's, when the Council was supportive of the Hospital Planning Council of Metropolitan Chicago. That support for planning has continued over the years, and we have encouraged our member hospitals to plan jointly and have assisted the comprehensive health planning agencies and, today, the Health Systems Agencies in their work.

The Council developed a "Workbook on Short-Term Planning" to aid hospitals in carrying out their own planning efforts. In addition, the Council has provided assistance to hospitals in completing the Workbook, or in carrying out other planning activities. The Workbook has been recognized by Federal and State health care planning officials, and over 75 percent of our member hospitals have completed it.

Metropolitan Chicago hospitals save over \$10 million a year through the Chicago Hospital Council's shared services programs. These programs are among the most mature in the nation and began developing in 1963. At that time, the Council developed a management consulting program. In 1965, the Council established a group purchasing program. Member hospitals purchased \$55 million worth of goods and services through the program in 1976 achieving savings of approximately \$6 million per year via the one service alone. In 1972, Chicago-area hospitals opened two shared laundry plans. They now provide complete linen and laundry service for 20 hospitals aggregating 7,700 hospital beds. Productivity of laundry workers employed in those facilities is over twice as high as the productivity of workers in the laundries replaced by the new facilities. In 1975 the Council began an unemployment compensation administration program which contests nonvalid claims and helps hospitals avoid avoidable unemployment compensation claims. The 65 participating hospitals are saving approximately \$2 million a year through that program.

One often hears about the existence of unnecessary obstetrical units. Yet, over the years the number of obstetrical units in metropolitan Chicago has declined by 20 percent. In 1963, there were 98 such units. There were 79 in 1976.

Further, growth in hospital beds in metropolitan Chicago has been generally consistent with growth in population and growth in admission rates. This would indicate that our work in areawide and institutional planning has been successful to a considerable extent. For example, in 1965-70, the population in metropolitan Chicago grew by 4.3 percent. Due to the time needed to construct new hospital facilities, we must look at the growth in the number of beds occurring about 5 years after a population change. Growth in the number of beds was 5.4 percent for the period 1970-75, a figure very close to the population growth figure. During the period 1970-75, hospital admissions grew by 11.6 percent in metropolitan Chicago, more than twice the growth rate for beds.

Reduction in the number of beds to that called for in S. 1391 would mean about 170,000 patients (about 17 percent) per year now accommodated in Chicago-area hospitals could not be admitted. Crowding would be such that the ability to hospitalize routine emergency patients and those injured in major disasters would be severely limited during many days of the year.

The proposed ceiling on capital expenditures will clearly mean a decline in availability of services and problems associated with inability to modernize or replace antiquated facilities. Assuming the capital expenditure allotment would be distributed based on population, about \$83 million in capital expenditures per year would be allowed in metropolitan Chicago. Yet, Chicago-area hospitals have been granted certificates of need amounting to about \$250 million per year for capital items. Further, many of the beds located in inner city areas are extremely antiquated and in need of replacement. However, the capital expenditures limit would make needed replacement and upgrading of facilities to meet current standards impossible.

Chicago-area hospitals have demonstrated their responsibility to contain costs in numerous ways. S. 1391 ignores such efforts and would actually penalize those that have been most efficient.

We must seriously question the Federal Government's ability to properly implement the program.—The Federal Government has demonstrated its inability to implement major programs in a timely and effective manner. For example, Public Law 92-603, the legislation authorizing establishment of Professional Standards Review Organizations, was approved in October 1972. Only now is the program being implemented in the Chicago-area's Cook County, with complete implementation not likely until the end of the year. Most of the rest of metropolitan Chicago does not even have a PSRO in the development state.

As another example, Public Law 93-641 was signed into law in January 1975. That law called for establishment of Health Systems Agencies which were not very dissimilar from the comprehensive health planning (b) agencies in place since passage of Public Law 89-749 in 1966. Yet, over 2 years after passage of Public Law 93-641, the Health Systems Agencies are still in their infancy and do not have completed plans with which to do their work.

General comments.—I have touched upon just a few of the many reasons why S. 1391 would be inequitable and a mistake. America has an excellent health care and hospital system, and S. 1391 would be a significant step toward destroying that system. We do need to take steps to attempt to contain increased health care costs. Hospitals in Chicago are anxious to work with government, industry,

and the public in doing so, and they have been attempting to contain costs for many years. However, S. 1391 does not pose that type of opportunity.

I hope our comments have been helpful. We would be pleased to provide additional information.

STATEMENT OF THE NEBRASKA METHODIST HOSPITAL

I appreciate having this opportunity to comment on the Hospital Cost Containment Act of 1977, H.R. 6575 and its companion bill in the Senate S. 1391. My comments will be limited to three areas: The deficiencies that exist in the bill; the impact of the bill upon Nebraska Methodist Hospital and the five hospitals which are managed through a non-profit division of the hospital and my recommendations for dealing with the increase in the cost of hospital care.

The primary deficiency in the bill is that an arbitrary cap is provided without considering the tremendous differences which exist between hospitals. Shared Service Systems, a non-profit division of Nebraska Methodist Hospital, currently manages five hospitals in Nebraska, Iowa and Missouri. These institutions include a 70-bed hospital in Fairfax, Mo., and 85-bed county-owned hospital in Harlan, Ia., 30-bed hospitals in Tilden and Plainview, Nebr., and the 100-bed Childrens Memorial Hospital in Omaha, Nebr. Each of these institutions has a different mix of services with different skill levels required among employees. Each institution has a different physical plant with varying needs for capital improvements. It is unrealistic to assume that a nine percent cap will work as well for each of these institutions as it does for 379-bed Nebraska Methodist Hospital, which provides such services as open-heart surgery and cancer therapy which require the use of intricate and expensive equipment.

The second major problem with the Hospital Cost Containment Act of 1977 is the fact that an arbitrary cap penalizes efficiently operated institutions. For example, Secretary Califano has stated that hospitals can provide significant savings through better use of energy. At Nebraska Methodist Hospital, we have installed equipment to use heat from exhaust air to warm incoming air in the winter. Lighting has been reduced. We are currently studying a computerized system to totally monitor the energy used in the hospital in the hopes of obtaining further savings. Because of these steps which have already been undertaken, it is going to be difficult to realize further significant savings in the energy area. Furthermore, by the end of 1977, we will no longer be able to use natural gas, but must switch entirely to oil. Because oil costs about four times what we pay for natural gas, we are going to experience a sharp rise in our energy costs during 1978.

Secretary Califano also suggests that significant savings can occur if hospitals use their present facilities more efficiently. Nebraska Methodist Hospital has averaged over 90 percent occupancy since 1970. On many days, we have a patient waiting list for elective procedures. Outpatient surgery and utilization review programs have been implemented to curtail hospital inpatient usage. Nebraska Methodist Hospital has achieved the lowest average adult length of stay (6.8 days) in metropolitan Omaha. Again, because of prior installation of efficiency programs, our present costs per patient day are at a minimum level. Hospitals that are operated less efficiently might consider similar programs, although some capital investments may be required. Cost increases, from external, uncontrollable sources, will force the reduction of patient services if our institution is to stay within a 9-percent cap.

The bill does not provide consideration for increased reimbursement for changes in patient mix. Hospitals will see an increase in intensity of services with the development of outpatient and home health care programs. These programs will hospitalize a more acutely ill group of patients who will necessarily have higher costs associated with their care.

Title II of the Act will ultimately have the most detrimental impact to the quality of health care. It is estimated that the nation's hospitals are required to spend about \$2.1 billion annually to replace obsolete equipment. A national ceiling of \$2.5 billion annually will not allow for purchase of new equipment which will improve health care, increase employee productivity, shorten our patients' length of stay and reduce the cost of patients' hospitalization.

Another point which must be considered is that much of the National Health Planning and Resources Development Act (Public Law 93-641) has not been implemented. The health care field is beginning to function within the requirements of this law, although the cost benefits have yet to be recorded or realized.

The imposition of the temporary controls, as outlined in the Hospital Cost Containment Act of 1977, and permanent controls within 2 years, will disrupt the hospital industry and curtail health care progress.

In studying the impact of the proposed legislation on Nebraska Methodist Hospital, I see several areas that make the bill unworkable.

Because our fiscal year does not coincide with the October 1 fiscal year established in the bill, it is going to be impossible for the hospital to budget for a full year and know with any certainty what increase will be allowed for the final quarter of our fiscal year. This makes intelligent planing and budgeting impossible.

Another difficulty in the bill, is that it does not consider the broad range of costs over which a hospital administrator or board of trustees has no control. For example, prudent management of any institution dictates that insurance be purchased for major risks. In the area of medical malpractice insurance, however, we have seen enormous increases in recent years. For example, in 1974, Nebraska Methodist Hospital paid \$63,000 for \$10 million of coverage. In 1977, the hospital had to pay \$485,000 for only \$5 million of coverage.

Nebraska Methodist Hospital, and more than 80 hospitals and nursing homes in Nebraska, Iowa, Kansas and Missouri purchase many of the goods needed daily in a hospital or nursing home from Shared Service Systems. Even with the \$6 million purchasing power of Shared Service Systems, for medical, surgical and food supplies, Nebraska Methodist Hospital has seen costs for many items rise significantly. For example: Coffee has risen from \$34.19 per case in Dec. 1975 to \$69.55 per case in March 1977. Intravenous solution has risen from \$4.24 per case to \$5.33 per case during the same period. Fluorescent bulbs have risen from \$18.62 to \$20.14 per case in that 15 month period.

Federal regulation has also added to the costs over which hospitals have no control. The Employee Retirement Income Security Act is one example. At Nebraska Methodist Hospital, we have been required to increase our contribution by \$240,000 from \$120,000 to \$360,000 in a recent 1-year period. The only thing that was changed in the pension program was the method of vesting—to bring the plan into compliance with the new law—and the cost.

The Congress is currently studying proposals to boost the minimum wage from \$2.30 per hour to \$2.50 or \$3 per hour. This proposal, along with the portion of the Hospital Cost Containment Act that provides for exemption of nonsupervisory wage increases, will tend to compress the wage scale within the hospital, and make the important first line supervisor jobs much less attractive. If the minimum wage is raised to \$2.50 per hour, and if some reasonable adjustments are made in wages for people with greater responsibilities, we could see as much as a nine percent increase in wage and salary expense, which comprises about 60 percent of our budget.

The capital expenditure limits are unrealistic because they do not consider area need, but divide the available dollars on a per capita basis. In Nebraska, it is estimated that our capital expenditures ceiling would be in the area of \$10 million. We have seen, in Omaha alone, one project which replaced an inefficient hospital constructed in the 1800's, and reduced the number of beds in the community, absorb more than \$70 million. Would this mean that one major construction project could absorb all capital expenditures available within a State, thereby requiring the use of obsolete equipment, or facilities, or the discontinuance of a service until a nonworking machine or unsafe facility can be replaced?

From this review of the bill, I hope that it is apparent that it is unrealistic, unworkable, and, in fact, a form of wage and price controls on one segment of one industry. I urge your rejection of this bill.

Nebraska Methodist Hospital is concerned about the cost of health care. We have taken a number of innovative steps to contain those costs, and we are willing to work in a constructive fashion with the Congress or with local or national associations in an attempt to provide an equitable solution to the problem.

To be equitable, however, there are certain things that any legislation passed by the Congress must consider. These include the difference that exist between hospitals, for all hospital beds are not the same. Different costs are associated with care in rural and metropolitan hospitals, primary, secondary or tertiary care hospitals, teaching hospitals and pediatric hospitals. Costs vary between private and public hospitals.

Differences in costs between hospitals for such items as capital, energy, medical malpractice insurance, educational programs, wage scales and other widely variable costs should be reimbursed under the present system.

A good program for cost containment should require only one financial audit which would serve all purposes. The same thinking should be applied to overlapping inspections and surveys by government at the Federal, State, and local levels as well as nongovernmental surveys. This would save a great deal of staff time and money for hospitals. In recent years, the flood of inspectors and auditors at our hospitals has included our own independent auditors, auditors for our medicare intermediary, the General Accounting Office from Baltimore and Kansas City, Internal Revenue Service, Department of Labor, Department of Health Education and Welfare, Joint Commission on Accreditation of Hospitals, state and city Departments of Health, Nebraska and Iowa State Department of Revenue, State and city fire marshals and the Occupational Safety and Health Administration.

I also recommend that all payors, including the Federal Government, pay billed charges, not costs. An independent review agency, similar to the Interstate Commerce Commission or the Federal Power Commission would approve hospital charges. The independent review agency would be composed of individuals who have an in-depth understanding of the health care delivery system and freedom from potential conflicts of interest. This program could eventually eliminate the need for Federal and State intermediaries which are now associated with titles V, XVIII and XIX of the Social Security Act.

The Federal Government should develop an alternative reimbursement formula which will allow hospitals with low occupancy to provide long-term care without applying proportional allocation of overhead costs to all patients in such facilities. (If all third party payors paid billed charges, this proposal would be unnecessary.)

Hospitals should be encouraged to provide shared services. Currently, revenue from shared services provided to hospitals larger than 100 beds, or revenue from shared laundry services, is considered unrelated business income. This discourages sharing of services which provides significant savings for health care facilities.

It seems apparent that a number of equitable methods exist for providing some containment of the rising cost of hospital care. It is my firm belief that a thorough discussion of the issues and a fair minded approach will result in containment of health costs which benefit the consumer of health care in the short run, and protect and enhance the finest health care system ever to exist, so that it will be good for the next generation of American health care consumers. Nebraska Methodist Hospital stands ready to assist, in whatever way possible, to insure that quality health care will be available at a reasonable price for all Americans.

STATEMENT OF THE SCIENTIFIC APPARATUS MAKERS ASSOCIATION

This statement is filed on behalf of the Scientific Apparatus Makers Association (SAMA), a voluntary national trade association with over 200 members. Within SAMA's membership, and especially within its Medical Devices and Diagnostics Section, are a substantial number of companies engaged in the manufacture and distribution of clinical laboratory instrumentation and equipment, acute care systems, related electro-medical equipment, and ophthalmic instruments. As suppliers of labor saving technology capable of providing better quality health care at less cost, these companies are highly interested in proposed legislation intended to contain health care cost increases and effect efficiencies in the delivery system.

SAMA SUPPORTS LEGISLATION TO BRING ABOUT GREATER COST CONSCIOUSNESS AND EFFICIENCY IN HEALTH CARE DELIVERY

That inflation in health care costs has spiralled upward at a much more rapid pace than general inflation is indisputable. While this fact is regrettable, SAMA nevertheless welcomes the attention it has focused on the need for greater cost consciousness as well as quality in the delivery of health care services. Not only does the present system lack incentives for rewarding efficiency and penalizing inefficiency, but it actually works in ways that produce disincentives. Among such disincentives are retrospective insurance reimbursement compensating providers for their costs regardless of whether or not they have performed efficiently, and insurance that provides greater coverage in the case of services performed on

an inpatient basis when the same services could often be much less expensively provided on an outpatient basis. For all these reasons, SAMA believes the time has come for legislative action directed at producing a much more cost conscious health care delivery system.

THE PROPOSED LIMITS ON CAPITAL EXPENDITURES ARE SEVERE AND WOULD BE COUNTER-PRODUCTIVE TO IMPROVING EFFICIENCY IN HEALTH CARE DELIVERY

We are concerned that several of the current legislative proposals are directed at effecting arbitrary limitations on expenditures without addressing the more fundamental need for greater efficiency. This is particularly true with regard to the proposed limitations on capital expenditures. With labor conservatively estimated at more than 55 percent of total costs, health care delivery is known to be a highly labor intensive industry. Where labor costs are high, experience has shown that the introduction of labor saving technology provides the best opportunity for achieving better efficiency. Yet several of the pending cost containment proposals would severely limit the amount health care providers could invest in labor saving technology.

The Hospital Cost Containment Act proposed by the Administration (S. 1391, H.R. 6575) would limit capital investments of \$100,000 or more by institutional providers to a total of \$2.5 billion per year. The bill reported out by the Senate Committee on Human Resources would declare a moratorium for an indefinite period on all capital expenditures over \$150,000 by all providers, both institutional and other. The bill currently under consideration by the House Interstate and Foreign Commerce Committee, H.R. 6575, would also declare an indefinite moratorium on capital expenditures over \$150,000 by all providers, and would permit the Secretary of Health, Education, and Welfare to extend this moratorium by regulation to purchases of less than \$150,000 considered not to be cost effective. On the other hand, the House Interstate and Foreign Commerce Committee has inserted a salutary but much too narrow exemption from the capital expenditure limitation for investments in hospital information systems found to be cost effective. The bill undergoing mark up before the House Ways and Means Committee currently includes the \$2.5 billion limitation on institutional capital investment contained in the Administration proposal.

The extent of current congressional concern over health care capital expenditures undoubtedly stems in large part from examples of investment in unneeded capacity adding to the health care cost without compensating health care benefits. That there has been duplicative investment cannot be disputed, but it does not follow that a moratorium or arbitrary limit on capital investment is likely to contribute substantially to reducing the rate of inflation in health costs without a sacrifice in the quality of health care. Proponents of a moratorium or limit on capital investment appear to base their position on assumptions, unsupported by data, that all forms of capital investment, including investment in technology, are currently contributing to the too rapid rise in health care cost inflation. In jumping to the conclusion that there is a casual relationship between heavy investment in health care technology and the rapid rate of health care cost inflation, they have lost sight of the fact that incentives to maximize the efficiencies made possible by labor saving technology are lacking in the health care delivery system as it exists today.

With regard to whether there is any definitive showing as to a relationship between investment in technology and increasing health care costs, the Congressional Budget Office, after considerable study, has stated that little is known about the effect of technology on health care costs and, "policy makers obviously need more information about the benefits and costs of new technologies to make objective decisions as to how much the nation should spend on them."* The Congressional Budget Office has also estimated that the Administration's proposed \$2.5 billion limitation on major hospital capital investment will reduce the amount otherwise to be invested in fiscal year 1978 by one-half. The moratorium proposed in other pending legislation would reduce this amount to zero. These are unquestionably severe limitations, and while there is reason to question whether all current capital investment can be justified, there is no basis for assuming that the current rate of major investment should be cut in half or eliminated.

*Expenditures for Health Care: Federal Programs and their Effects, Congress of the United States, Congressional Budget Office, Washington, D.C., August 1977.

We firmly believe that any limit on health care investment would be unwise, but if there is to be a limit, it should be developed from real knowledge of what the actual capital requirements are, based on cost/benefit analyses of investments in technology and taking into account the likely development of new efficiency-producing technology. Given the lack of any valid indication that investments in technology have contributed to the rapid inflation in health care costs, and given the experience of all other industries indicating that it is primarily through investment in labor saving technology that meaningful efficiencies are achieved, for the Congress arbitrarily to legislate a limit on investment in health care technology would at best be a highly dangerous policy and one that would most likely prove counterproductive to the underlying goal of achieving greater efficiencies in health care delivery.

THE PROPOSED REVENUE LIMIT WILL NOT CAUSE PROVIDERS TO CHANNEL LIMITED INVESTMENT INTO THE MOST EFFICIENT PROJECTS

Assuming that a portion of the current level of hospital investment has resulted in some excesses, merely imposing an arbitrary ceiling will not assure that only the wise portion of capital expenditures will be made in the future. It might be argued that an investment ceiling coupled with a limit on revenue increases will assure that institutions eliminate all investment projects except those which can be most efficiently operated. This is not the case. The institutional forces currently causing unwise investment will continue to prevail until sufficient means for rewarding efficiency are generated. While the proposed legislation would require investment within the limit to be approved by either a State planning agency or HEW, adequate criteria for evaluating such investment do not now exist. Furthermore, the institutions will control which projects are presented for approval and when they are presented. Our experience indicates that those institutions not infrequently rate other projects above investment in labor saving technology that increases productivity while moderately altering customary hospital routines. Perhaps the most serious problem with arbitrary limits, however, stems from the danger that the health care community will turn its attention to how to get pet projects within the limits rather than to the comprehensive planning anticipated by Public Law 93-641 and which is so vitally needed.

DIAGNOSTIC AUTOMATION HAS REDUCED COSTS

Some supporters of capital expenditure limitation have cited the increased expenditure for diagnostic testing as one of the reasons why an investment limit is needed. However, diagnostic testing can clearly be shown to have the potential for substantially reducing health costs. It is only the cost effectiveness of the use made of diagnostic testing that can be questioned since it can clearly be shown that investment in diagnostic automation is cost effective. Assurance of proper use of diagnostic resources can best be achieved by introducing efficiency incentives into the overall health delivery system and by more effective use of Professional Standards Review Organizations—approaches SAMA wholly supports. On the other hand, limiting or discouraging automation would be counterproductive to achieving greater efficiency.

The manufacture and sale of diagnostic instrumentation is highly competitive. As a result of this competition, many different instrument systems are offered, and a laboratory has an array of competitive and complementary equipment from which to choose. There are instruments designed for mass profiling, those which are dedicated to providing information on the function of a particular organ, such as the heart, liver, or kidney, instruments for measuring enzymes, and instruments which yield immediate results at a relatively low volume for use at times when higher volume equipment cannot be effectively used. Within each of these categories there are instruments offering differing levels of performance so as to meet the particular needs of small, medium, and large hospital laboratories. The range of available and competitive equipment is such that any laboratory can select components to make up the system that will be most cost effective for its unique needs.

Because of the high level of competition in this industry, manufacturers of automated equipment for clinical laboratories typically do cost analysis studies for their potential customers to determine in each case whether cost saving will result from the purchase of an automated instrument. The studies follow recognized methodologies developed by professional societies. These studies may indi-

cate to the hospital that the purchase of the instrument would not be cost effective, or they may demonstrate that the hospital could save money by increasing the degree of laboratory automation. We submit that cost effectiveness studies such as these are much more consistent with hospital cost containment objectives than an arbitrary across-the-board investment limitation or moratorium.

As an example of how diagnostic automation has been shown to be effective one cost/benefit study found that a hospital laboratory with an annual volume of 31,764 tests could save \$10,581 by the introduction of one automated analyzer, reducing its total testing costs from \$63,376 to \$52,795. (Total cost includes depreciated purchase price of instrument, supplies, cost of running quality control tests, and labor.) The savings in labor costs projected (\$28,210.50 or 6269 man hours) were so great that even with an increase of \$17,629.50 in nonlabor costs, the net savings of \$10,581 resulted. The study found that introduction of the automated equipment would reduce the average cost per test in this hospital from \$2.00 to about \$1.66, assuming no increase in the number of tests performed.

A recent study done for a medium-sized New York hospital showed that the introduction of new automation would reduce the cost per day for performing its existing volume of testing from \$1414 to \$891, a 37 percent reduction. Another New York hospital has been able to achieve a fivefold reduction in cost per test over the period 1965-1976: its experienced cost per test was \$0.51 in 1976 as compared to \$2.81 in 1966. This reduction was achieved notwithstanding the high rate of inflation in the economy, nearly 80 percent, occurring during this period. Published statistics based on a survey of 1,800 hospitals by the American Hospital Association show that there is a continuing trend of lower cost per test and increased productivity for hospitals of all sizes. These statistics (see attachment A) also show that while the cost per test has gone down, the volume of testing has increased at such a rate that total testing costs have risen. However, the first two examples cited above demonstrate clearly that automation is capable of reducing costs without an increase in volume.

AN INCREASED VOLUME OF TESTING IS CAPABLE OF REDUCING OVERALL HEALTH CARE COSTS

Supporters of investment limits also charge that the increased volume of diagnostic testing is largely attributable to the volume made possible by automation. There are, however, other valid reasons which can be cited as more likely causes for the increase in volume of testing. First of all, any effective program for evaluating the necessity for hospital admissions must rely on increased preadmission testing. Thus the Government's own program for reducing unnecessary hospital admissions has created a substantial requirement for new testing. More important, however, is the increased emphasis on early disease detection and preventive medicine as a means of bringing about a reduced need for expensive therapy and treatment.

The importance of early diagnosis in permitting a pathological condition to be most efficiently and effectively treated is well known, and the important role that diagnostic testing plays in the early detection of disease can be readily demonstrated. Compiling a history of data on a patient's physical state plays a necessary part in preventive medicine and such information can only be obtained by diagnostic testing.

Some indication of the predictive value of diagnostic testing is provided by a study performed by Dr. Ralph Theirs in 1965 at Duke University Hospital and the Durham Veterans Administration Hospital in North Carolina. Initially the laboratory performed the tests on each patient which the physician had ordered based on his preliminary diagnosis. This initial testing produced 150 indicated abnormalities per 1,000 patients. An additional 10 tests were performed on each of the patients and these additional 10 tests revealed 210 unsuspected abnormalities per 1,000 patients. Investigation of these abnormalities in turn led to a change of diagnosis or treatment for 38 percent of the patients involved. Had this additional testing not been performed, it is clear that many early diagnoses would have been missed. It is also clear that many disease states would have been inefficiently treated because of a lack of relevant information on the patient's physical condition.

The example just cited further demonstrates that testing provides medically useful information not obtainable in any other way. The fact that such information has not been as effectively used as possible to provide better diagnosis and care at less cost in every case is due more to the current lack of incentives for

efficient operation in the delivery system. Testing information is clearly useful in ruling out potentially serious diagnoses and permitting outpatient care where more expensive hospitalization would have been required were it not possible to rule out the more critical diagnosis otherwise indicated by patient complaints. Greater efficiency can also be achieved in managing therapy by the effective use of diagnostic testing.

The availability of more accurate and effective diagnostic tests conveniently deliverable at reasonable costs may well have made a major contribution to the recent decline in the average length of hospital stays—a decline which should have resulted in significant cost reductions. The fact that hospital costs have continued to escalate at the same rapid pace despite the reduction in average length of stay provides the best evidence yet of the need for efficiency incentives. Services and resulting costs have not been reduced to reflect the fact that the average length of hospitalization is declining. Instead costs continue to be incurred as if the average length of stay had not been shortened, and such costs are spread over a reduced base thus causing an increase in unit costs. This inefficiency should not be charged to the increased volume of diagnostic testing, the results of which clearly could have been used to effect economies that were not in fact effected.

THE BROADER SOCIAL AND ECONOMIC COSTS OF FAILING TO PROVIDE QUALITY HEALTH CARE MAY BE MUCH GREATER THAN THE DIRECT COST OF PROVIDING SUCH HEALTH CARE

Up to this point we have been concerned only with the direct costs of providing health care. This is too narrow a focus, and we must not lose sight of the fact that failure to provide quality health care presents broader cost implications in both human and economic terms. For example, the making of renal dialysis readily available to patients with chronic kidney failure has increased significantly our health care cost burden. Nevertheless, since this program clearly saves lives and permits persons who would otherwise be invalid to continue to be productive, the country and the Congress have judged this cost to be worthwhile. It would be unfair and unreasonable to criticize the use of technology that has been so successful in meeting the objectives of such government programs.

In recent years new technology has evolved permitting close and continuous monitoring of the vital signs of persons in critical condition in intensive or coronary care units. These systems, generally called acute care systems, play a role at least as important as dialysis in maintaining life and permitting persons who might otherwise be invalid to continue useful and productive lives. These systems afford the most efficient means of providing this vitally needed service. They increase health care costs only because there is no alternative way to accomplish equivalent life saving and prevention of invalidism. That acute care systems are expensive to maintain and operate is readily admitted, and we therefore agree that there is a need for effective planning to assure that such facilities are not duplicative and underutilized. However, effective planning provides the only means of achieving such efficiency—it will not be brought about by arbitrary limitations on capital investment.

RECOMMENDATIONS

While the Scientific Apparatus Makers Association strongly opposes controls on health care capital investment, we are nevertheless committed to a legislative program of introducing efficiency incentives into the health care delivery system. We submit that the Medicare-Medicaid Reimbursement and Reform Act of 1977, S. 1470, represents the best approach for introducing the needed incentives. The promptest possible implementation of a prospective reimbursement system like that proposed in S. 1470 is strongly supported by our Association. If, in the interim, it is decided that temporary controls capable of more immediate application are required, we would not oppose a reasonable temporary limitation on hospital revenues. While we are not in a position to advise regarding what a reasonable limitation should be, testimony by others in hearings on the hospital cost containment bills has persuaded us that the limit proposed by the administration is too arbitrary. The alternatives recently proposed by Senator Talmadge appear more reasonable. We would also urge that insurers be required to end the current practice of covering procedures performed on an inpatient basis that are not covered when provided on a less expensive outpatient basis.

Our opposition to capital investment controls extends only to an arbitrary limit on the amount that can be invested. We recognize that there is a need to

assure that such investment is well-directed. For this reason we support the strengthening of the Health Planning and Resources Development Act (Public Law 93-641), to require certificates of need for capital expansion over \$150,000. We also support the fastest possible implementation of this law as well as more intensive review by Professional Standards Review Organizations of the quality and need for health services. While we believe that diagnostic testing must play an important role in cost effective health care delivery, we would agree that this role needs to be better defined. We will cooperate in any effort aimed at objectively determining the role that diagnostic testing can play in the provision of quality health care.

6 MO NATIONAL AVERAGE (BY BED SIZE)¹

	Under 50	50-74	75-99	100-149	150-199	200-299	300-399	Over 400
Tests/admission:								
Dec. 31, 1974-----	12.59	15.55	16.97	19.38	20.97	25.78	30.45	32.38
June 30, 1976-----	14.94	18.54	20.95	22.41	24.49	28.95	35.71	37.53
Direct expense/test (excluding fees):								
Dec. 31, 1974-----	\$2.06	\$1.69	\$1.70	\$1.67	\$1.70	\$1.42	\$1.29	\$1.30
June 30, 1976-----	\$1.91	\$1.71	\$1.61	\$1.64	\$1.63	\$1.39	\$1.27	\$1.23
Tests/man-hour:								
Dec. 31, 1974-----	4.46	5.14	4.77	5.13	4.52	5.42	5.75	5.49
June 30, 1976-----	5.18	6.05	6.32	5.82	5.74	6.33	6.89	5.52

¹ Based on 6 mo of data from over 1,800 hospitals stratified by bed size.

Source: Hospital Administrative Services, American Hospital Association.

STATEMENT OF BARBARA B. BEST, REGISTERED DIETITIAN, MANAGER, DIETARY SPECIALTIES, GENERAL MILLS CHEMICAL, INC.

Revisions in medicare coverage in the treatment of chronic renal disease can result in improved care and an annual governmental savings of \$157,206,000 (based on 1976 costs and one-half number of people currently on dialysis).

I am urging you to support (b) portion of the experiments and studies section of H.R. 8423 which requires the Secretary to conduct "experiments and studies to evaluate methods for reducing the costs of the renal disease program including experimentation . . . and evaluations of the cost savings potential . . . of methods of dietary control."

It is my belief that special dietary foods used in the treatment of renal disease should be covered by medicare. Providing for additional studies in this area is a first step in that direction.

Glaring inconsistencies in current interpretations of Medicare coverage in the treatment of chronic renal disease result in excessive and unnecessary expenditure of Federal funds. For example, it is possible to substantially reduce the costs of treating a patient by using special dietary foods. Current interpretations of the law provide payment of the costs for dialysis treatment; however, Medicare coverage for special dietary foods which can be used to delay or decrease dialysis is not provided. The result is that governmental expenditures are significantly higher than necessary and persons who are too poor to afford the costs of the special dietary program which could delay or decrease dialysis have no alternative except to frequently dialyze. Furthermore, the social costs—in terms of mental anguish, pain and suffering of a patient compelled to have a symbiotic attachment to a machine—cannot be calculated.

As the kidney deteriorates in chronic renal disease it is especially important that sufficient protein to prevent tissue protein catabolism be consumed and yet not so much as to elevate urea levels. Further, by controlling the intake of electrolytes such as sodium and potassium as well as protein and fluid, it has been found at the Mayo Clinic that dialysis can be delayed or carried out on a more infrequent basis.

Objectives to be used in planning a diet for chronic renal disease patients are stated as follows in "Nutrition and Diet Therapy" by Sue Rodwell Williams:

1. Reduce and minimize protein catabolism.
2. Avoid dehydration or overhydration.
3. Carefully correct acidosis.
4. Correct electrolyte depletions and avoid excesses.
5. Control fluid and electrolyte losses from vomiting and diarrhea.

6. Maintain nutrition and weight.
7. Maintain appetite and morale.
8. Control complications such as hypertension, bone pain, and central nervous system abnormalities.

Consuming a diet meeting these criteria is extremely difficult unless special dietary foods are included. Nutrients which are carefully controlled in these foods are protein, sodium, potassium and fluid.

Following is a quotation from "Nutritional Therapy for Adults With Renal Disease" as published January 1, 1973 in the Journal of the American Medical Association:

"During the past decade, advances in nutritional therapy, along with development of long term hemodialysis therapy and renal transplantation, have added immeasurably to the possibilities of treatment for chronic uremia. Of the three methods, only nutritional therapy is applicable in every case."

By following a diet of the previously mentioned type, dialysis can in many cases be delayed or the patient may be dialyzed less frequently. Further, less frequent dialysis often means less loss of productive work time and thus more earned money. Additionally, there are numerous patients who have an aversion to the dialysis machine. Thus, it can be understood that using special dietary foods in the treatment of renal disease can contribute to dollars saved, patient dollars earned and better quality care.

Such irregularities as currently exist in the Medicare law allowing for coverage of dialysis but not special dietary foods need to be corrected. This change alone could have meant an annual governmental savings (with one half patients following program) of \$157,206,000 in 1976 or a savings of \$336,870,000 in 1981.

Explanatory background

Estimated cost of dialysis—1976-----	\$500, 000, 000
Estimated number of people on dialysis—1976-----	28, 000
Annual patient dialysis cost (3 times/week)-----	\$17, 857
Annual patient dialysis cost (1 time/week)-----	\$5, 952
Annual patient cost of special foods (\$13/week)-----	\$676
Annual patient cost of dialysis (1 time/week) plus special foods---	\$6, 628
Annual savings per patient with dialysis 1 time/week plus special foods -----	\$11, 299
Possible annual governmental savings 1976-----	\$314, 412, 000
With ½ patients on dialysis 1 time/week plus special foods---	\$157, 206, 000
Expected dialysis patients by 1981-----	60, 000
With ½ patients on dialysis 1 time/week plus special foods---	\$336, 870, 000

Possible governmental savings with dialysis 1 time/week plus special foods

1976:	
With all patients following this program-----	\$314, 412, 000
With ½ patients following this program-----	157, 206, 000
1981:	
With all patients following this program-----	\$673, 740, 000
With ½ patients following this program-----	336, 870, 000

In summary, combining a therapeutic diet utilizing special dietary products with dialysis when appropriate can:

1. Decrease Medicare payments.
 2. Reduce hospitalization cost.
 3. Multiply cost savings by patients.
 4. Increase earning capacity of selected patients.
 5. Help cut down on frequency of dialysis treatment, thereby making these facilities available to more patients.
 6. Decrease mental anguish, pain and suffering of patients.
 7. Reduce the economic burden on renal patients who require special foods.
- Each individual patient's specific treatment must, of course, be recommended and monitored by medical personnel. It is, however, in the taxpayers' interests as well as those of the patient that special dietary foods be covered by medicare.

During the last ten years General Mills, Inc. and General Mills Chemicals, Inc. in cooperation with the Mayo Clinic and other research groups have developed special low protein products which can be used by people who cannot utilize normal kinds of amounts of protein. These "foods for the few" continue to be used by individuals with chronic renal disease and other disorders such as celiac-sprue and phenylketonuria. Since this hearing is limited to renal disease, coverage of special foods for other disorders will not be discussed. This, however, is an area crying out for rectification. Substantial governmental savings could be affected by applying similar principles to other conditions.

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS,
Chicago, Ill., October 11, 1977.

HON. HERMAN TALMADGE,
*Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate,
Washington, D.C.*

DEAR SENATOR TALMADGE: The Blue Shield Association is following with much interest the Congressional debate on hospital cost-containment. In this respect, we commend you and your staff for your thoughtful alternative to the Administration's proposal and we hope this week's hearings will help bring about a consensus on this difficult problem. But as you know, BSA is more attuned to physician reimbursement issues, so we are not at this time seeking to testify on the various proposals to limit hospital revenues.

We do, however, want you to know that we do actively support another section of S. 1470; namely, the general prohibition against disclosure of aggregate payments to physicians under Medicare and Medicaid (Section 44). As it is now, the Medicare Bureau is developing procedures and a timeable for publication of all 1977 physician incomes, in apparent conformity with existing law. Based on those evolving procedures, together with the abundant lessons we all learned from HEW's earlier disclosure of 1975 data, we at Blue Shield have the following concerns:

HEW is shifting responsibility for preparation of the income data from government to the Medicare contractor community.

Publication of all physicians' income derived from the Medicare program will be a particularly difficult and costly administrative effort. The Medicare Bureau itself estimates that costs to prepare such listings will exceed \$1 million. That figure does not include manual intervention by contractor personnel when physicians challenge the data.

It will be extremely difficult to compile an absolutely accurate list. Numerous errors were discovered when the 1975 calendar year list was first published. This list contained only 2,200 names. Calendar year 1977 data is estimated to involve some 220,000 physicians and suppliers. Therefore, the likelihood of even more errors being made will be drastically increased when that list is published.

We therefore urge that Section 44 be carried forward in S. 1470, or as a separate amendment to other legislation if need be.

Also, Mr. Chairman, we would take this opportunity to express our support for H.R. 8423, the House-passed bill designed to improve Medicare administration and operation of coverage for patients suffering from kidney failure. The particulars of our position—and a few qualifications—are set forth in the attached testimony by California Blue Shield, submitted last April to the Subcommittee on Health of the House Committee on Ways and Means. In brief, we believe the bill will expand desirable benefits while at the same time encouraging cost-containment in the Medicare program. However, our testimony urges thoughtfulness and caution in balancing those cost savings against quality services, and in extending review functions, controls, and networks.

We will be glad to furnish you with any additional information or details on these matters. Again, we hope your upcoming hearings on H.R. 8423 and S. 1470 and related proposals are productive.

Very truly yours,

WILLIAM E. RYAN,
President.

Enclosure.

STATEMENT OF BLUE SHIELD ON END-STAGE RENAL DISEASE

(Presented by Charles W. Stewart, Executive Vice President, Blue Shield of California)

Mr. Chairman and members of the Subcommittee, I am Charles W. Stewart, Executive Vice President, Blue Shield of California. I am also Co-Chairman of the Carrier Representative Group, an organization which represents the Medicare carriers at large with the Bureau of Health Insurance. In all, 31 carriers are Blue Shield Plans which process Part B or physician claims under the program. In addition, I am a member of the National Association of Blue Shield Plans' Government Affairs Committee. With me today is Charles B. Sonneborn, Vice President of the National Association of Blue Shield Plans.

We very much appreciate the opportunity to appear before this Subcommittee to express our views regarding H.R. 3112. The End-Stage Renal Disease Program overall has been a very successful and efficient program. We have seen particularly how people have often been helped in heretofore hopeless situations. The proposed legislation will extend and enhance those benefits and encourage cost-containment in the Medicare program. We are here to endorse this legislation.

We have a few concerns, however, which we feel Congress should address before passing this legislation.

One, Mr. Chairman, is the question of incentives. We notice that the major incentive in H.R. 3112, to encourage home dialysis, rests with the provider through authority given to a review board to impose financial penalties. Yet, no real incentives are held out for the user, other than the convenience factor. This convenience option, I am afraid, could very well be offset by the patient's or family's preference to have the work done at an institutional center. We recommend, therefore, that consideration be given to stronger incentives for the beneficiary to actively elect the lower cost treatment methods.

Of equal concern, however, is that the legislation may force all patients to receive dialysis at home and it is clear that not all may have the capable family support to carry on this process. It may be best, therefore, to have the physician review mechanism working together with carriers and intermediaries evaluate not only the patient but the home environment as well to determine the best and most appropriate site of treatment. We would like to recommend that this criteria be developed through already existing review mechanisms rather than through legislation. We feel that the existing environment can best attest to the quality of care in a local environment as well as the cost issue for the purchase of equipment.

The assumption behind the cost aspects of this proposal is that home dialysis is cheaper than center or institutionally-based treatment. Therefore, if more patients receive treatment at home, the cost to the program will be reduced.

It is a fact that the current provider reimbursement formula used for the program pays less for home treatment. It may also be true, as many spokesmen have been saying, that home units are less expensive than those used in the centers. It has also been stated that the purchase of home units is more cost efficient than renting such equipment.

Whether it is true that shifting treatment from institutional centers to home care will be more cost effective in the long run or not, we cannot answer at this time. While data has been published showing that the average cost per treatment in a home care setting is substantially lower than the cost under the existing program for clinical treatment, we would suggest that these figures may not be comparable. For example, we cannot say to what extent the limited allowances for home care treatment under the existing program have influenced the estimated figures for treatment in the absence of such controls. We also do not know how much increase there will be in fee-for-service costs for support of home care if the categories of qualified home care patients are increased.

These statements are not made to cast any question upon the desirability of implementing the proposed amendments. The key question should not focus on making available treatment that is effective for the patient and increases the diversity of health care offerings to patients. Under the present program, the incentives seem to have worked to require that most End-Stage Renal care be conducted in the clinical environment.

We think that this amendment goes a long way towards providing a more adequate diversity that permits a more appropriate consideration of patient environment and medical requirement without losing sight of cost control concerns.

There may appear in the marketplace expensive and attractive dialysis equipment which most patients, if given a choice, will prefer. Yet, there may also be less costly and less attractive equipment available which could perform just as efficiently as will the higher cost item. Similarly, there may be circumstances under which certain supplies and replacement items could be safely used longer than might be ordinarily anticipated or even desired by the patient. If this practice could be encouraged or assured it would dampen the unnecessary purchase of costly items. Again, we recommend that existing review mechanisms can best make this determination.

In summary, Mr. Chairman, we are here to say that Blue Shield supports the overall intent to H.R. 3112 in its attempt to expand desirable benefits and encourage cost-containment in the Medicare program. However, we urge thoughtfulness and caution in balancing cost savings against quality services, and in extending review functions, controls, and networks.

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, D.C., November 9, 1977.

HON. HERMAN TALMADGE,
Chairman, Health Subcommittee, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is a very thoughtful and articulate letter I have received from Mr. Raymond Rund of Finley, N. Dak., concerning the need for legislation to provide better medicare coverage for kidney dialysis at home.

I understand your committee is currently considering legislation on this subject, H.R. 8423. During your work on this bill, I would urge that you give very careful attention to the concerns, needs, and problems Mr. Rund has described for I believe he makes an excellent case for prompt passage of it. I would also ask that his letter be made a part of the record on H.R. 8423, and that your subcommittee act promptly on this legislation when Congress reconvenes in January.

With kind regards, I am,
Sincerely,

QUENTIN N. BURDICK.

Enclosure.

RAYMOND R. RUND,
Finley, N.D., October 31, 1977.

Senator QUENTIN BURDICK,
*Senate Office Building,
Washington, D.C.*

DEAR SENATOR BURDICK: I would like to urge you and the members of Congress to pass legislation which will allow Medicare or HEW to pay for the cost of training a nurse or technician to operate kidney dialysis machines, and to participate in paying for either 80 percent or 100 percent of that person's salary while operating the machine in a home, rather than in a hospital setting.

My wife had kidney failure about 10 days ago, and was told that her kidney function would not return. She is 62 years old, and may yet be a candidate for a kidney transplant, though the usual program ends at age 60, we were told. With no outpatient insurance, and little inpatient insurance, you can imagine the catastrophic effect it had on us. Since she had cancer operations back in 1945, she was unable to purchase hospital and doctor insurance either on an individual or on a group rate. She finally was able to purchase a very limited policy of inpatient coverage, paying 75 percent of some of the medicines and \$30 a day hospital room at a cost of \$558.21 from Bankers Life and Casualty Company, with a two year waiting period for preexisting conditions. She obtained this policy in March of 1973, and is virtually the only coverage she has. Blue Cross and Blue Shield would not take her on, on any program, and I understand they pay all of the costs for both inpatient and outpatient treatment which medicare does not pay. We are not that fortunate.

We were told at Hennepin General Hospital, in Minneapolis last week that after January 1, 1978, medicare would pay for 80 percent of the in hospital dialysis treatment, which includes supplies and the technician who operates the machine. But, that if we wanted to go to home dialysis, we would have to pay the entire cost of a 4 to 6 week training course for the operator, which cost would be \$5600, plus \$5000 for my wife's treatment on the machine on which the operator trains, plus the operator's and my wife's expenses while the training program is ongoing. Then after the home dialysis machine is put into place, we must pay for 100 percent of the operator's wages while he or she is working in the home for about 8 hours a day, 3 days a week. This makes the home dialysis treatment more expensive than a hospital treatment. We live 90 miles from the treatment center in Fargo, where we would go for treatment, and must find a way to transport my wife both to and from Fargo on a 3-time-a-week basis. My wife would have to be there 1 hour before the 6 hour treatment begins, and it takes about 2 hours to make the trip one way. One can hardly imagine the burden placed on any person to do it as a patient, being on the road or in the hospital for 11 to 12 hours a day, every other day, just to be treated at the medical center. It would be much better for the patient to be treated at home if at all possible, providing that the cost of training the technician and the technician's wages were participated in, by medicare.

I practice law in a rural, North Dakota city, with a population of under 1,000, and if I were required to spend 3 days out of my office on the road or in the hospital sitting with my wife, I would soon be out of business. It is as simple as that. So, besides the catastrophic effect upon the patient, it has the same effect on the spouse who wants to earn a living and pay for the cost of the treatment. Without the treatment, she would die within days or weeks.

I understand there is a bill before Congress now, which addresses itself to paying the cost of training the technician to operate the dialysis machine. I am not sure if it is going to pass, and if it does, what part does it pay? Also, to make a home dialysis treatment worthwhile, it would have to pay for the wages or part of the wages of the operator in the home setting. Medicare currently pays for 80 percent of the technician's wages, etc. in a hospital setting. Why not do so in the home? Were we living very close to a hospital, so we could commute easily, it would be much less expensive there than to operate and rent a machine and supplies at home.

For example, I was told that the cost, without the doctor's fees, for the supplies, machine, and operator in a hospital setting in Fargo would be about \$2,300 a month. After we pay for the first 3 months, medicare pays 80 percent or we pay \$460 per month for three 6-hour treatments. I was also told that for a home unit, and supplies, the monthly cost would be \$1,000. If medicare pays 80 percent we would pay \$200. However, we must add to that, the wages of the technician, which they said would be from \$400 to \$500 per month, and we then have a home dialysis which costs more than a hospital setting dialysis, and that makes no sense to me. It would save the expense of travel, and wear and tear on the patient to stay at home, but it certainly discriminates against a patient that is unfortunate enough to live 50, 90 or 100 or more miles from the hospital treatment center.

As I see it, our only salvation would be for the quick enactment of a bill which would pay for part or all of the technician's training and on the job pay, to make the home dialysis treatment less expensive. If the dialysis expense will not break me financially, the trips on the road to a medical treatment center, and my being absent from my office will certainly do it. So, one way or another, it would seem, that for me, I am looking at certain financial ruin, unless help comes our way. Many people across this Nation must be in the same identical situation. I ask that you give this your most urgent consideration and priority.

I have been a sole practitioner for most of my professional life, which started in 1941, and I have prided myself as being able to make a decent living and to pay my bills. However, what has been thrust upon me in recent days has me worried, and my future here is uncertain. Surely, many small operators, farmers, businessmen face the same thing that I am, when kidney failure strikes in the family. It is a catastrophe, and while other illnesses also strike the same way, this one is acute, for to sustain life, for even a few days, the patient must be hooked to a machine.

While National Health Care may be a long way off, and even may never come, it would take too much of a debate to pass that kind of legislation. We need something built into medicare program now to provide immediate help. As for me, if you and the Congress waits too long, it will come too late for me.

I surely hope that this lengthy letter will be read, and that it will not be just a cry in the wilderness. You have here a genuine, down to earth need that needs to be filled all across this Nation, and I am hopeful that something will be done very soon to help.

Respectfully yours,

RAYMOND R. RUND.

[Material Received by the Committee, December 16, 1977.]

APPENDIX

LIST OF COMMUNITY HOSPITALS WITH ANNUAL INCREASES IN TOTAL EXPENSE PER INPATIENT ADMISSION LESS THAN 9 PERCENT FOR THE PERIOD 1974 TO 1976

This is a list of 189 community hospitals in the United States and its possessions which experienced annual increases in total expense per inpatient admission less than 9 percent for both 1974-75 and 1975-76. Community hospitals are defined according to the definition used by the American Hospital Association: all non-federal short-term general and other special hospitals—excluding hospital units of institutions (e.g., prison and college infirmaries)—whose facilities and services are available to the public. The source of the data used in compiling this list is the American Hospital Association. (Office of the Deputy Assistant Secretary for Planning and Evaluation/Health. Department of Health, Education, and Welfare.)

COMMUNITY HOSPITALS WHERE C BELOW 9 PERCENT FOR BOTH TIME PERIODS

Hospital	1976-75	1975-74
Auxilio Mutuo Hospital, San Juan, P.R.	-4.59	3.04
Guam Memorial Hospital, Agana, Guam	-.14	3.28
Northern Maine Medical Center, Fort Kent, Maine	-.14	7.39
Exeter Hospital, Exeter, N.H.	2.91	-48.83
Fanny Allen Hospital, Winooski, Vt.	8.57	7.93
Beverly Hospital, Beverly, Mass.	5.64	6.11
Boston City Hospital, Boston, Mass.	-8.81	7.62
Hunt Memorial Hospital, Danvers, Mass.	-1.31	3.27
Addison Gilbert Hospital, Gloucester, Mass.	5.14	7.83
Melrose-Wakefield Hospital, Melrose, Mass.	.15	5.72
Nantucket Cottage Hospital, Nantucket, Mass.	8.99	7.31
Glover Memorial Hospital, Needham, Mass.	8.54	7.04
Josiah B. Thomas Hospital, Peabody, Mass.	8.61	3.65
Berkshire Medical Center, Pittsfield Mass.	7.80	8.74
Salem Hospital, Salem, Mass.	2.77	6.87
Child's Hospital, Albany, N.Y.	8.08	8.61
Arnold Gregory Memorial Hospital, Albion, N.Y.	4.69	7.79
Mary McClellan Hospital, Cambridge, N.Y.	5.49	7.39
St. James Mercy Hospital, Hornell, N.Y.	7.69	7.88
Doctors Hospital, New York, N.Y.	2.97	8.42
Hospital for Joint Diseases, New York, N.Y.	6.13	-7.12
Jewish Memorial Hospital, New York, N.Y.	7.46	6.69
Medical Arts Center Hospital, New York, N.Y.	6.00	8.04
Memorial Hospital for Cancer, New York, N.Y.	3.47	5.43
Montefiore Hospital and Medical Center, Bronx, N.Y.	-7.79	8.59
Champlain Valley Physicians Hospital Medical Center, Plattsburgh, N.Y.	6.66	3.75
Mountainside Hospital, Montclair, N.J.	5.89	3.29
Sacred Heart General Hospital, Chester, Pa.	5.85	8.21
Ellwood City Hospital, Ellwood City, Pa.	8.10	8.02
Koval-Getter Hospital, Hazleton, Pa.	7.04	-2.32
Rehabilitation Hospital for Specific Services, Mechanicsburg, Pa.	8.22	-.73
D. W. Seidle Memorial Hospital, Mechanicsburg, Pa.	5.88	-42.58
Somerset Community Hospital, Somerset, Pa.	1.13	6.78
Good Samaritan Hospital, Baltimore, Md.	6.90	-7.66
Provident Hospital, Baltimore, Md.	8.03	-6.47
Memorial Hospital at Easton, Md.	.54	6.92
Culpeper Memorial Hospital, Culpeper, Va.	-35.53	7.30
South Boston General Hospital, South Boston, Va.	.31	5.29
Wise Appalachian Regional Hospital, Wise, Va.	8.28	4.19
Shenandoah County Memorial Hospital, Woodstock, Va.	8.10	1.55
St. Joseph's Hospital, Buckhannon, W. Va.	6.82	-30.49
Boone Memorial Hospital, Madison, W. Va.	7.17	-12.47
Pocahontas Memorial Hospital, Marlinton, W. Va.	-4.12	8.80
Hugh Chatham Memorial Hospital, Elkin, N.C.	-3.82	7.10

COMMUNITY HOSPITALS WHERE C BELOW 9 PERCENT FOR BOTH TIME PERIODS—Continued

Hospital	1976-75	1975-74
Southern Wake Hospital, Fuquay, N.C.	6.62	-1.33
Highlands-Cashiers Hospital, Highlands, N.C.	5.92	-10.68
Iredell Memorial Hospital, Statesville, N.C.	7.85	7.50
Warren General Hospital, Warrenton, N.C.	-6.23	1.93
Kershaw County Memorial Hospital, Camden, S.C.	8.74	8.95
Southwest Community Hospital, Atlanta, Ga.	2.17	4.52
Bleckley County Hospital, Cochran, Ga.	-3.82	2.45
DeKalb General Hospital, Decatur, Ga.	8.44	5.30
L. W. Blake Memorial Hospital, Bradenton, Fla.	6.59	-14.36
South Lake Memorial Hospital, Clermont, Fla.	3.89	-.88
Imperial Point Hospital, Fort Lauderdale, Fla.	-5.99	7.28
Florida Keys Memorial Hospital, Key West, Fla.	3.09	-12.66
Lake Community Hospital, Leesburg, Fla.	-.27	-10.25
Wuesthoff Memorial Hospital, Rockledge, Fla.	8.90	7.07
O'Brien Memorial Hospital, Athens, Ohio	3.47	8.65
Salvation Army Booth Memorial Hospital, Cleveland, Ohio	8.22	-.97
Pike County Hospital, Waverly, Ohio	8.14	-9.99
Margaret Mary Community Hospital, Batesville, Ind.	3.07	2.78
Community Hospital of German Township, Bremen, Ind.	.41	3.51
Jennings Community Hospital, North Vernon, Ind.	6.22	-60.29
Wirth Osteopathic Hospital, Oakland City, Ind.	8.62	8.24
Fairfield Memorial Hospital, Fairfield, Ill.	5.77	5.49
Crawford Memorial Hospital, Robinson, Ill.	-3.10	-28.93
Rochelle Community Hospital, Rochelle, Ill.	6.58	7.51
Eaton Rapids Community Hospital, Eaton Rapids, Mich.	8.86	6.47
Genesee Memorial Hospital, Flint, Mich.	3.69	6.57
Pipp Community Hospital, Plainwell, Mich.	7.17	3.85
St. Mary's Hospital Medical Center, Green Bay, Wis.	4.21	2.27
Lad Memorial Hospital, Osceola, Wis.	5.33	.30
St. Croix Valley Memorial Hospital, St. Croix Falls, Wis.	-17.47	2.60
Harlan Appalachian Regional Hospital, Harlan, Ky.	6.64	4.36
Appalachian Regional Hospital, South Williamson, Ky.	1.85	8.78
McClellan County General Hospital, Calhoun, Ky.	6.06	4.99
East Tennessee Children's Hospital, Knoxville, Tenn.	5.16	8.43
Scott County Hospital, Oneida, Tenn.	-13.14	3.85
Lakeshore Hospital, Birmingham, Ala.	-16.85	-6.49
Grove Hill Memorial Hospital, Grove Hill, Ala.	3.63	-.07
Cleburne Hospital, Heflin, Ala.	-8.68	-25.35
Sumter Memorial Hospital, Livingston, Ala.	-12.36	6.52
Good Samaritan Hospital, Selma, Ala.	2.99	-1.97
Selma Medical Center Hospital, Selma, Ala.	-.24	5.61
Sylacauga Hospital, Sylacauga, Ala.	4.85	-14.96
Bullock County Hospital, Union Springs, Ala.	-.19	2.16
Abernethy Memorial Hospital, Flomaton, Ala.	3.22	-6.92
Lawrence County Hospital, Moulton, Ala.	4.23	-1.40
District Two Community Hospital, Durant, Miss.	6.34	6.24
St. Dominic-Jackson Memorial Hospital, Jackson, Miss.	5.68	2.06
Laurel General Hospital, Laurel, Miss.	4.16	2.14
Tyler Holmes Memorial Hospital, Winona, Miss.	7.69	.36
Douglas County Hospital, Alexandria, Minn.	6.60	8.57
White Community Hospital, Aurora, Minn.	2.40	3.40
Community Memorial Hospital, Elbow Lake, Minn.	3.77	1.89
Fosston Municipal Hospital, Fosston, Minn.	5.96	-152.05
Minnesota Valley Memorial Hospital, Le Sueur, Minn.	6.37	8.86
Littlefork Municipal Hospital, Littlefork, Minn.	-7.07	6.32
Paynesville Community Hospital, Paynesville, Minn.	4.94	5.52
Community Memorial Hospital, Hartley, Iowa	6.43	-16.56
Humboldt County Memorial Hospital, Humboldt, Iowa	.97	.62
John McDonald Hospital, Monticello, Iowa	7.53	-51.62
Hand Community Hospital, Shenandoah, Iowa	7.36	5.39
Osceola Community Hospital, Sibley, Iowa	6.76	6.55
Aurora Community Hospital, Aurora, Mo.	-15.43	3.38
Cooper County Memorial Hospital, Boonville, Mo.	3.87	-9.78
Liberty Hospital, Liberty, Mo.	5.26	-6.63
Richardton Community Hospital, Richardton, N. Dak.	-4.51	5.41
Rolla Community Hospital, Rolla, N. Dak.	6.60	-10.12
Community Bailey Hospital, Chamberlain, S. Dak.	6.48	5.82
St. Joseph's Hospital, Deadwood, S. Dak.	-8.49	-3.42
Ipswich Community Hospital, Ipswich, S. Dak.	2.95	-8.46
Community Memorial Hospital, Redfield, S. Dak.	5.10	-.63
Phelps Memorial Health Center, Hildrege, Nebr.	-4.72	4.84
Sacred Heart Hospital, Loup City, Nebr.	-20.67	7.38
Kearney County Community Hospital, Minden, Nebr.	5.04	4.97
Rushville Community Hospital, Rushville, Nebr.	2.32	-19.03
Tilden Community Hospital, Tilden, Nebr.	2.58	6.78
St. Margaret's Mercy Hospital, Fredonia, Kans.	4.69	7.17
Halstead Hospital, Halstead, Kans.	6.52	7.80
Mercy Hospital, Independence, Kans.	7.34	8.90
Kearny County Hospital, Lakin, Kans.	-4.47	-2.02
Hamilton County Hospital, Syracuse, Kans.	1.11	-29.94
Chickasawba Hospital, Blytheville, Ark.	5.75	5.93
Medical Center of Calico Rock, Calico Rock, Ark.	2.54	-1.32
Lafayette County Memorial Hospital, Lewisville, Ark.	-2.51	3.50

COMMUNITY HOSPITALS WHERE C BELOW 9 PERCENT FOR BOTH TIME PERIODS—Continued

Hospital	1976-75	1975-74
Arkansas Children's Hospital, Little Rock, Ark.....	8.76	-15.24
Our Lady of the Lake Hospital, Baton Rouge, La.....	- .39	6.07
De Quincy General Hospital and Clinic, De Quincy, La.....	5.09	5.20
Franklin Foundation Hospital, Franklin, La.....	2.34	3.50
E. S. Pike Memorial Hospital, Kentwood, La.....	8.50	2.62
Lake Charles Charity Hospital, Lake Charles, La.....	.20	3.16
Arbuckle Memorial Hospital, Sulphur, Okla.....	4.40	7.48
Jefferson County Hospital, Waurika, Okla.....	2.72	7.74
Archer County Hospital, Archer City, Tex.....	7.81	2.27
Haltom General Hospital, Fort Worth, Tex.....	-10.44	3.63
Blackwell Hospital, Gorman, Tex.....	7.94	.40
Grapevine Memorial Hospital, Grapevine, Tex.....	6.69	-9.15
Hi-Plains Hospital, Hale Center, Tex.....	7.70	-28.28
Irving Community Hospital, Irving, Tex.....	1.46	-16.29
Mercy Hospital, Jourdan, Tex.....	5.15	-10.25
Sid Peterson Memorial Hospital, Kerrville, Tex.....	6.29	-4.24
Lubbock Osteopathic Hospital, Lubbock, Tex.....	-2.37	-.05
Cochran Memorial Hospital, Morton, Tex.....	-5.71	-8.46
Newton County Memorial Hospital, Newton, Tex.....	4.88	1.01
Metropolitan General Hospital, San Antonio, Tex.....	5.18	-37.60
San Antonio Community Hospital, San Antonio, Tex.....	-3.02	.50
Guadalupe Valley Hospital, Seguin, Tex.....	1.15	4.53
D. M. Cugdell Memorial Hospital, Snyder, Tex.....	1.54	-16.89
Stephenville Hospital, Stephenville, Tex.....	8.44	8.90
Bozeman Deaconess Hospital, Bozeman, Mont.....	3.71	7.91
St. Johns Lutheran Hospital, Libby, Mont.....	4.69	-38.77
Malta Hospital, Malta, Mont.....	6.24	5.41
Clark Fork Valley Hospital, Plains, Mont.....	-1.32	-.36
Community Hospital, Poplar, Mont.....	-6.34	.49
Prarie Community Hospital, Terry, Mont.....	-9.15	6.63
St. Alphonsus Hospital, Boise, Idaho.....	8.03	6.59
St. Anthony Community Hospital, Pocatello, Idaho.....	8.30	.25
Beth Israel Hospital and Geriatrics Center, Denver, Colo.....	2.07	-10.78
Haxtun Hospital District, Haxtun, Colo.....	-53.50	-13.62
Salida Hospital, Salida, Colo.....	6.02	-3.40
Wray Community District Hospital, Wray, Colo.....	5.05	2.35
Roosevelt General Hospital, Portales, N. Mex.....	-44.30	2.46
Lake Havasu Community Hospital, Lake Havasu City, Ariz.....	.60	-2.56
Mesa General Hospital, Mesa, Ariz.....	2.60	8.61
Pima County General Hospital, Tucson, Ariz.....	-6.12	-12.12
Duchesne County Hospital, Roosevelt, Utah.....	-4.99	1.93
Mount Grant General Hospital, Hawthorne, Nev.....	6.23	-1.81
Southern Nevada Memorial Hospital, Las Vegas, Nev.....	8.47	8.88
Humboldt General Hospital, Winnemucca, Nev.....	3.91	-27.45
North Las Vegas Hospital, North Las Vegas, Nev.....	-12.10	2.25
Othello Community Hospital, Othello, Wash.....	7.86	6.89
McKay Memorial Hospital, Soap Lake, Wash.....	5.40	5.19
Albany Hospital, Albany, Calif.....	-3.93	-3.99
Mono General Hospital, Bridgeport, Calif.....	-1.98	4.01
Humboldt Medical Center, Eureka, Calif.....	-3.18	-59.45
Memorial Hospital of Hawthorne, Hawthorne, Calif.....	8.10	3.78
Saddleback Community Hospital, Laguna Hills, Calif.....	6.96	-20.11
Mountains Community Hospital, Lake Arrowhead, Calif.....	-18.10	8.70
Los Altos Hospital, Long Beach, Calif.....	3.30	4.21
Norwalk Community Hospital, Norwalk, Calif.....	7.80	-7.53
Allisal Community Hospital, Salinas, Calif.....	-6.51	6.87
Community Hospital of San Diego, San Diego, Calif.....	-104.29	4.26
Tuolumne General Hospital, Sonora, Calif.....	-10.89	-19.71
Medical Center of Tarzana Hospital, Tarzana, Calif.....	-1.49	-16.74
Sutter County General Hospital, Yuba City, Calif.....	2.50	-20.74
Wrangell General Hospital, Wrangell, Alaska.....	-.17	-151.63
Kaiser Foundation Hospital, Honolulu, Hawaii.....	-15.64	4.81

Note: 22,392 records processed; 189 hospital records written.



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